

Application Instructions for:

MESSAGE THERAPIST LICENSURE FOR EXISTING PRACTITIONERS USE THIS APPLICATION ONLY IF YOU WERE AN EXISTING PRACTITIONER ON OCTOBER 9, 2010

**THIS APPLICATION MUST BE RECEIVED IN THE OFFICE OF THE STATE BOARD OF
MESSAGE THERAPY NO LATER THAN JULY 31, 2012.**

All licenses expire on January 31 of odd-numbered years. **You will be required to complete the 24 continuing education requirements in order to renew your license.** You may renew your license beginning 60 days before your current license expiration date. You may not practice massage therapy unless you hold a current license.

CHECKLIST FOR APPLICANTS:

SECTION 1: COMPLETE ALL:

- ___ Complete, sign and date the application.
- ___ Enclose a check or money order in the amount of \$65.00. The check or money order should be made payable to the Commonwealth of Pennsylvania. The fee is not refundable.
- ___ Attach a copy of a legal form of identification, such as a driver's license, a current passport, or a valid state identification card. The copy should be submitted on an 8 ½ x 11 sheet of paper.
- ___ Attach the Certification of Good Moral Character form, filled out and signed by two individuals, who are not related to you, who have known you for at least six months.
- ___ An official Criminal History Record Check (CHRC) from the state agency for every state in which you have resided for the past 5 years. The report(s) must be dated within 6 months of the date of your application as an existing practitioner. This report can be sent to you and forwarded to the Board with your application. For Pennsylvania CHRC, this can be done online at <http://epatch.state.pa.us>.
 - ___ a. If you have a criminal record, attach certified court documents related to the conviction(s) and a personal statement explaining the conviction(s) and what you have done since the conviction(s) that demonstrates that you are rehabilitated.

Section 1 continued:

_____ Attach a copy of the front & back of your current Adult Basic CPR certification, including the expiration date of your CPR certification. Your card must be signed and if applicable, a copy of the legend must be included. The copy should be submitted on an 8 ½ x 11 sheet of paper. **Online CPR is not acceptable.**

_____ If you are licensed in another state, request each state in which you now hold or ever held (active or inactive, current or expired) a **massage therapy license** to forward a "Letter of Good Standing" **directly** to the Board in a sealed official state board envelope.

SECTION 2: SUBMIT ONE (1) ONLY:

EVERY applicant for licensure as an existing practitioner must demonstrate that he or she conducted a business and actively participated in that business that was mainly the practice of massage therapy during the period that ended on October 9, 2010.

_____ **1.** A **signed** copy of the applicant's Federal tax return for 2010, that lists the applicant's occupation as a massage therapist.

_____ **2.** A **signed** copy of Schedule C of the applicant's Federal tax return for 2010, demonstrating that the individual has reported income from the practice of massage therapy.

_____ **3.** Proof sent directly from a Board-approved professional association, of professional or practitioner membership level or above showing membership no later than October 9, 2010. A list of Board-approved professional associations is on the Board's website, www.dos.state.pa.us/massagetherapy.

_____ **4.** For applicants who have been employed as massage therapists, a notarized statement from the applicant's employer (on the Board's "Employer Verification" form) attesting that the individual is a practicing massage therapist, a copy of the employer's business card or letterhead, and a copy of the applicant's Federal W-2 or 1099 form.

SECTION 3: SUBMIT ONE (1) ONLY:

In addition, every applicant must submit **ONE** of the following:

_____ **1.** Demonstrate that the applicant has been in active, continuous practice between October 9, 2005, and October 9, 2010. In order to demonstrate **active, continuous practice**, submit **one** of the following:

_____ **a.** **Signed** copies of the applicant's Federal tax returns from 2005 through 2009 years, each listing the applicant's occupation as massage therapist.

Section 3 continued

____b. **Signed** copies of Schedule C or other tax return schedule of the Federal tax return from 2005 through 2009 demonstrating that the applicant has reported income from the practice of massage therapy.

____c. Proof, sent directly from a Board-approved professional association, of at least 5 years membership at the professional or practitioner level or above in the professional association. The time frame must include **October 9, 2005 through October 9, 2010**. A list of Board-approved professional associations is on the Board's website at www.dos.state.pa.us/massagetherapy.

____d. For applicants who have been employed as massage therapists, a notarized letter from the applicant's employer (on the Board's "Verification of Five Years Employment" form) attesting that the individual has practiced massage therapy for at least 5 years, a copy of the employer's business card or letterhead and copies of the applicant's Federal W-2 or 1099 forms from **2005-2009**.

____2. Demonstrate that the applicant passed a National Certification Board examination. Have NCBTMB (www.ncbtmb.org) send scores to the PA State Board of Massage Therapy.

____3. Demonstrate that the applicant has completed a massage therapy educational program of at least 500 hours. To meet this section, have your school complete the "Verification of Massage Therapy Education" form.

____4. Demonstrate that the applicant has completed a massage therapy educational program of at least 100 hours and has passed the MBLEx examination. If you chose to demonstrate your qualification for licensure in this manner, submit the "Verification of Massage Therapy Education" form and have your examination scores sent directly to the Board by the Federation of State Massage Therapy Boards at www.fsmtb.org.

NAME OR ADDRESS CHANGE:

If the name you are currently using on your application is different than the name you used on any of the other documents required to be submitted with your application, or if you change your name after you submit this application, send evidence of your name change within ten (10) days. For example, send a copy of marriage certificate or court order authorizing the name change.

If your address changes after you have submitted your application, notify the Board office in writing of your name, old address and new address. Mail this information to the Board office at the address shown above within ten (10) days.

OTHER INFORMATION:

Maintain a copy of all documents sent to the Board. Send your application materials to the Board at: State Board of Massage Therapy, PO Box 2649, Harrisburg, PA 17105-2649 OR (for courier delivery) 2601 North Third St, Harrisburg, PA 17110.

You may view the Massage Therapy Law and the regulations of the Board online at www.dos.state.pa.us/massagetherapy.

April 2012

Regular Mailing Address:

State Board of Massage Therapy
P.O. Box 2649
Harrisburg, PA 17105-2649
Phone: 717-783-7155

Courier Delivery Address:

State Board of Massage Therapy
2601 North Third Street
Harrisburg, PA 17110
email: RA-massagetherapy@state.pa.us

**MESSAGE THERAPIST LICENSURE for EXISTING PRACTITIONER APPLICATION
THIS APPLICATION MUST BE RECEIVED IN THE OFFICE OF THE STATE BOARD OF
MESSAGE THERAPY NO LATER THAN JULY 31, 2012.**

MAKE \$65.00 FEE PAYABLE TO "COMMONWEALTH OF PENNSYLVANIA". NOT REFUNDABLE OR TRANSFERABLE. A PROCESSING FEE OF \$20.00 WILL BE CHARGED FOR ANY CHECK OR MONEY ORDER RETURNED UNPAID BY YOUR BANK, REGARDLESS OF THE REASON FOR NON-PAYMENT.

NAME _____

Last

First

Middle

Maiden/Other name used

ADDRESS _____

Street

City

State

Zip Code

SOCIAL SECURITY # _____

BIRTHDATE _____

PHONE NUMBER _____

EMAIL ADDRESS _____

EXAMINATION

I have completed one of the following Board approved examination in massage therapy:

NCETM _____ YES _____ NO

NCETMB _____ YES _____ NO

MBLEx _____ YES _____ NO

EDUCATION

As required by Section 5 (a)(2), have you earned a high school diploma or equivalent? Yes _____ No _____

Include in chronological order high school and all massage therapy schools attended.

INSTITUTION AND LOCATION (Include city and state)	DATES ATTENDED	DIPLOMA, DEGREE OR CERTIFICATE AWARDED, If any
H.S.	From To	
M.T.	From To	
	From To	
	From To	

ANSWER THE FOLLOWING: If you answer "YES" to question(s) 2-5, give details on a separate 8 ½ X 11 sheet of paper AND provide a certified copy of all related official documentation.	YES	NO
1. Have you previously taken the National Certification Examination for Therapeutic Massage (NCETM), the National Certification Examination for Therapeutic Massage and Bodywork (NCETMB) or the Massage and Bodywork Licensure Examination (MBLEx)? If YES , give the exam MONTH and YEAR and to which STATE the results were reported: _____		
2. Do you use or abuse alcohol, drugs, narcotics, chemicals or any other type of material that would impair your practice of massage therapy?		
3. Have you been convicted, found guilty or pleaded nolo contendere, or received probation without verdict or accelerated rehabilitative disposition (ARD) as to any felony or misdemeanor or do you have any criminal charges pending and unresolved in any state or jurisdiction? You are not required to disclose any criminal matter that has been expunged by order of a court.		
4. Have you ever possessed a license or other authorization to practice massage therapy or other occupation where you provide services to the public? If YES , list license type and state of issue: _____		
5. Have you ever withdrawn an application for a license or other authorization to practice massage therapy or any other occupation, denied or refused, or agreed not to reapply for a license in another state, territory or country? If YES , provide an explanation.		
6. Have you ever had a license or other authority to practice an occupation disciplined – including imposition of a fine, reprimand, suspension or revocation. If YES , name the license, state of issue and attach a copy of the disciplinary action: _____		

VERIFICATION

I verify that the statements in this application are true and correct to the best of my knowledge, information and belief. I understand that false statements are made subject the penalties of 18 PA C.S. Section 4904 relating to unsworn falsification to authorities and may result in the suspension or revocation of my licensure or registration. **I verify that I have read and am familiar with the provisions of the Pennsylvania Massage Therapy Law and regulations of the State Board of Massage Therapy (www.dos.state.pa.us/massagetherapy).** I also verify that this form is in the original format as supplied by the Department of State and has not been altered or otherwise modified in any way. I am aware of the criminal penalties for tampering with public records or information pursuant to 18 PA C.S. Section 4911.

 Printed Name of Applicant

 Signature of Applicant

 Date

Note that disclosing your social security number on this application is mandatory in order for the State Board of Massage Therapy to comply with the requirements of the Federal Social Security Act pertaining to child support enforcement, as implemented in the Commonwealth of Pennsylvania at 23 Pa. C.S. § 4304.1(a). In order to enforce domestic child support orders, the Commonwealth's licensing boards must provide to the Department of Public Welfare information prescribed by DPW about the licensee, including the social security number. Additionally, disclosing the number is mandatory in order for this board to comply with the reporting requirements of the Federal Healthcare Integrity and Protection Data Bank. Reports to the HIPDB must include the licensee's social security number.

State Board of Massage Therapy

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Certification of Good Moral Character

To be completed by two individuals who have known you for at least six months. Do not use individuals who are related to you. **ORIGINAL SIGNATURES ARE REQUIRED.**

Name of Applicant: _____

I hereby certify that I have known the applicant for at least 6 months and that the applicant has good moral character. I recommend the applicant for a license to practice massage therapy in the Commonwealth of Pennsylvania.

I have been personally acquainted with the applicant for _____ year(s) _____ month(s).

SIGNATURE: _____ Date: _____

Print or type name as signed above: _____

State in which licensed: _____ License Number: _____
(if applicable)

Name of Applicant: _____

I hereby certify that I have known the applicant for at least 6 months and that the applicant has good moral character. I recommend the applicant for a license to practice massage therapy in the Commonwealth of Pennsylvania.

I have been personally acquainted with the applicant for _____ year(s) _____ month(s).

SIGNATURE: _____ Date: _____

Print or type name as signed above: _____

State in which licensed: _____ License Number: _____
(if applicable)

Return Completed Form to Applicant

April 2012

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VERIFICATION OF MASSAGE THERAPY EDUCATION
Applicant for Licensure for **EXISTING PRACTITIONERS**

Applicant: Complete (by typing/printing in blue/black ink) top section and send form to your Massage Therapy program to complete and attach your transcripts.

NAME _____

ADDRESS _____

SOCIAL SECURITY # _____ DATE OF BIRTH _____

This section to be completed by the Dean, Registrar, or Chairperson of the Massage Therapy program at the United States school which the applicant COMPLETED. DO NOT complete this form in anticipation of program completion.

I hereby certify that:

1) _____ successfully completed a Massage
(Applicant's name)
Therapy education program at _____ on _____.
(School name) (Date)

2) The curriculum included _____ hours of instruction in Massage Therapy and related
(Number of hours)
subjects.

3) The school is :
 A Pennsylvania Private Licensed School
 Operated within a regionally accredited College or University

(Name of College or University)
 Approved by the MT Board or Department of Education of _____
(State)

(Printed Name & Signature of Dean/Registrar/Chairperson of M.T. Program)

(Date)

Name of Program _____

SEAL Name of Controlling Institution _____

Address _____

SCHOOL SHALL RETURN AN ORIGINAL COMPLETED FORM DIRECTLY TO BOARD OFFICE IN AN OFFICIAL ENVELOPE AND ATTACH STUDENT TRANSCRIPTS. (DO NOT send a copy of this form or use envelope if provided by applicant)

April 2012

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Harrisburg, PA 17110
email: RA-massagetherapy@state.pa.us

EMPLOYER VERIFICATION FORM

Who must submit this form:

An existing practitioner demonstrating, through employer verification, that he/she has conducted a business and been an active participant in that business that was mainly the practice of massage therapy. The applicant's employer must complete this form.

I certify that _____ has been practicing massage
(Name of Applicant)

therapy and has been in my employment as a massage therapist.

Dates of employment as a massage therapist: From _____ to _____.

I have attached copies of my business card/letterhead and the applicant's Federal W-2 or 1099 form for all the years verified.

Name of business _____
Address of business _____
Phone number of business _____

Printed name and Signature of Employer

Date

NOTARY INDIVIDUAL ACKNOWLEDGEMENT

COMMONWEALTH OF PENNSYLVANIA
COUNTY OF _____

On this, the _____ day of _____, 20____, before me _____, the undersigned officer, a notary public, personally appeared _____ known to me (or satisfactorily proven) to be the person whose name is subscribed to the within instrument, and acknowledged that he executed the same for the purposes therein contained.

In witness hereof, I hereunto set my hand and official seal.

Notary stamp and signature

This form must be submitted to the Board office directly from the employer.

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Harrisburg, PA 17105-2649
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VERIFICATION OF FIVE YEAR EMPLOYMENT FORM

Who must complete this form:

An existing practitioner demonstrating, through employer verification, that he/she has been practicing massage therapy for at least the 5 years immediately preceeding October 9, 2010. The applicant's employer must complete this form. Use as many forms as necessary to show 5 years of continuous employment as a massage therapist.

I certify that _____ has been practicing massage
(Name of applicant)

therapy and has been in my employment.

Dates of employment as a massage therapist: From _____ to _____.

I have attached copies of my business card/letterhead and copies of the applicant's Federal W-2 or 1099 forms for all the years verified.

Name of business _____

Address of business _____

Phone number of business _____

Printed name and Signature of Employer

Date

NOTARY INDIVIDUAL ACKNOWLEDGEMENT

COMMONWEALTH OF PENNSYLVANIA
COUNTY OF _____

On this, the _____ day of _____, 20____, before me _____, the undersigned officer, a notary public, personally appeared _____ known to me (or satisfactorily proven) to be the person whose name is subscribed to the within instrument, and acknowledged that he executed the same for the purposes therein contained.

In witness hereof, I hereunto set my hand and official seal.

Notary stamp and signature

This form must be submitted to the Board office directly from the employer.