Massage Therapist Licensure Application

Florida Board of Massage Therapy
PO Box 6330
Tallahassee, FL 32314-6330
Web: www.floridasmassagetherapy.gov
Email: info@floridasmassagetherapy.gov

Do Not Write in this Space For Revenue Receipting Only

Fees must be paid in the form of a cashier's check or money order, made payable to: Department of Health

Choose your application type:

Massage Therapist by Examination (X-1021) ☐ **$155.00**
Massage Therapist by Endorsement (X-1022) ☐ **$155.00**

The total fee of $155.00 includes the following:

Initial Licensure Fee	$100.00
Application Fee	$50.00
Unlicensed Activity Fee	$5.00

An applicant, who is denied licensure, or withdraws the application prior to licensure, is entitled to a refund of $105.00 (initial licensure fee and unlicensed activity fee). A request to withdraw and/or receive a refund must be made in writing. Fees are refundable for up to 3 years from the date of receipt.

1. PERSONAL INFORMATION

Name: ______________ Last/Surname ______________ First ________ Middle **Date of Birth:** ________ MM/DD/YYYY

Mailing Address: (The address where mail and your license should be sent.)

______________ Street/ PO Box ________ Suite/Apt. No ________ City

________ State ______ Zip ____________ Country ____________ Home/ Cell Number

Physical Location: (Required if mailing address is a PO Box. This will be posted on the Department's website.)

______________ Street/ PO Box ________ Suite/Apt. No ________ City

________ State ______ Zip ____________ Country ____________ Work/ Cell Number

Equal Opportunity Data: We are required to ask that you furnish information as part of your voluntary compliance with Section 2, Uniform Guidelines on Employee Selection Procedure (1978) 43 CFR38295 and CFR38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

SEX: ☐ Male ☐ Female

RACE: ☐ White ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ Hispanic ☐ American Indian or Alaska Native ☐ Two or More Races

Email Notification: If you want to be notified of the status of your application by email, please check the "Yes" box and write your email address on the line provided below. If you choose this form of notification, you will receive information regarding your application file through email. You will be responsible for checking your email regularly and updating your email address with the Board office at: info@floridasmassagetherapy.gov

I want to be notified by email: **Yes** **No**

Email Address: ______________________________

Under Florida law, email addresses are public records. If you do not want your e-mail address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

NAME ____

2. MASSAGE THERAPY EDUCATION HISTORY

A. **Massage Therapy School Graduated From:** ____

_______________________________ Street ______________________ City ________ State ______________ Country

B. Date Graduated/ Anticipated Graduation (mm/dd/yyyy) : _____________

C. **Additional Massage Therapy School Attended:** ____

_______________________________ Street ______________________ City ________ State ______________ Country

D. Date Graduated/ Anticipated Graduation (mm/dd/yyyy) : _____________

E. I authorize the school(s) listed above to release my official transcript(s) directly to the Florida Board of Massage Therapy. **Yes** **No**

3. APPLICANT BACKGROUND

A. List any other name(s) by which you have been known in the past.

____

B. List all health related licenses you have ever held (active, inactive or lapsed).

State/Country	Profession	License No.	Date Of Licensure

4. FLORIDA LAWS AND RULES COURSE

Completion of a ten (10) hour course on Florida Laws and Rules is required prior to licensure. This course must be completed with from a Florida Board of Massage Therapy approved CE provider or massage school.

I attest I have completed the required course listed above. **Yes** **No**

If you checked "No", you must submit your course completion certificate to the Board office.

5. DISCIPLINARY HISTORY

If you answer "Yes" to any of the questions in this section, you are required to send the following items:

- **Self Explanation,** describing in detail the circumstances surrounding the disciplinary action.
- A copy of the **Administrative Complaint and Final Order**.

A.	Yes	No	Have you ever been denied or is there now any proceeding to deny your application for any healthcare license to practice in Florida or any other state, jurisdiction or country?
C.	Yes	No	Have you ever had disciplinary action taken against your license to practice any healthcare related profession by the licensing authority in Florida or in any other state, jurisdiction or country?
B.	Yes	No	Have you ever surrendered a license to practice any healthcare related profession in Florida or in any other state, jurisdiction or country while any such disciplinary charges were pending against you?
D.	Yes	No	Do you have any disciplinary action pending against your license?

Failure to disclose information in the above section may result in a denial of your application.

NAME ____

6. CRIMINAL HISTORY

If you answer "Yes" to any of the questions in this section, you are required to send the following items:

- **Self Explanation** describing in detail the circumstances surrounding each offense; including dates, city and state, charges and final results.
- **Final Dispositions and Arrest Records** for all offenses. The Clerk of the Court in the arresting jurisdiction will provide you with these documents. Unavailability of these documents must come in the form of a letter from the Clerk of the Court.
- **Completion of Sentence Documents**. You may obtain document from the Department of Corrections. The report must include the start date, end date and that the conditions were met.

A. Yes No Have you **EVER** been convicted of, or entered a plea of guilty, nolo contendere, or no contest to, a crime in any jurisdiction other than a minor traffic offense? You must include all misdemeanors and felonies, even if adjudication was withheld.

Reckless driving, driving while license suspended or revoked (DWLSR), driving under the influence (DUI) or driving while impaired (DWI) are not minor traffic offenses for purposes of this question.

B. Yes No Have charges ever been brought against you by any branch of the United States Armed Services?

Failure to disclose information in this section may result in a denial of your application.

7. CRIMINAL AND MEDICAID/MEDICARE FRAUD QUESTIONS

Applicants for licensure, certification or registration and candidates for examination may be excluded from licensure, certification or registration if their felony conviction falls into certain timeframes as established in Section 456.0635(2), Florida Statutes. If you answer "Yes" to any of the following questions, please provide a written explanation for each question including the county and state of each termination or conviction, date of each termination or conviction, and copies of supporting documentation to the board office. Supporting documentation includes court dispositions or agency orders where applicable.

1. Yes No Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction?

If you responded "No" to the question above, skip to question 2.

a. Yes No If "Yes" to 1, have you successfully completed a drug court program for a felony offense that resulted in the plea being withdrawn or charges dismissed?

b. Yes No If "Yes" to 1, for felonies of the first or second degree, has it been more than 15 years before the date of application?

c. Yes No If "Yes" to 1, for felonies of the third degree, has it been more than 10 years before the date of application, except for felonies of the third degree under Section 893.13(6), Florida Statutes?

d. Yes No If "Yes" to 1, for felonies of the third degree under Section 893.13(6)(a), Florida Statutes, has it been more than 5 years before the date of application?

NAME ____

2. ☐ Yes ☐ No Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)?

If you responded "No" to the question above, skip to question 3.

a. ☐ Yes ☐ No If "Yes" to 2, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation for such conviction or plea ended?

3. ☐ Yes ☐ No Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes?

If you responded "No" to the question above, skip to question 4.

a. ☐ Yes ☐ No If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years?

4. ☐ Yes ☐ No Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid Program?

If you responded "No" to the question above, skip to question 5.

a. ☐ Yes ☐ No Have you been in good standing with a state Medicaid program for the most recent five years?

b. ☐ Yes ☐ No Did the termination occur at least 20 years before the date of this application?

5. ☐ Yes ☐ No Are you currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities?

8. EXAMINATION HISTORY

Please indicate which of the following licensure examinations you have passed.

Name of Examination	State/Country	Month/Year
☐ NCBTMB	____________	___________
☐ NCETM	____________	___________
☐ NESL	____________	___________
☐ MBLEX	____________	___________
☐ Other: _________________	____________	___________

9. AVAILABILITY FOR DISASTER

☐ Yes ☐ No Will you be available to provide health care services in special needs shelters or to help staff disaster medical assistance teams during times of emergency or major disaster?

NAME ____

CONFIDENTIAL AND EXEMPT FROM PUBLIC RECORDS DISCLOSURE*

10. HEALTH HISTORY (Supporting documentation should be sent directly to the board office)

If you answer “Yes” to any of the questions in this section, you are required to send the following items:

- **Self Explanation,** explaining the medical condition(s) or occurrence(s) and current status.
- **Letter(s) from Licensed Professional** summarizing diagnosis, treatment and prognosis; or any other official documentation as it relates to any “Yes” answer. Documentation must be current within the last year.

A. ☐Yes ☐ No In the last five years, have you been enrolled in, required to enter into, or participated in any drug or alcohol recovery program or impaired practitioner program for treatment of drug or alcohol abuse?

B. ☐Yes ☐ No In the last five years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental disorder or impairment?

C. ☐Yes ☐ No During the last five years, have you been treated for or had a recurrence of a diagnosed mental disorder that has impaired your ability to practice massage therapy?

D. ☐Yes ☐ No During the last five years, have you been treated for or had a recurrence of a diagnosed physical disorder that has impaired your ability to practice massage therapy?

E. ☐Yes ☐ No In the last five years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol/drug) disorder or, if you were previously in such a program, did you suffer a relapse?

F. ☐Yes ☐ No During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol/drug) disorder that has impaired your ability to practice massage therapy?

Name: ______________________ ____________________ ____________________

Last **First** **Middle**

Social Security Number: ______________________________________

Pursuant to 466(a)(13), 42 U.S.C. § 666(a)(13), the department is required and authorized to collect Social Security Numbers relating to applications for professional licensure. Additionally, section 456.013(1)(a), Florida Statutes, authorizes the collection of Social Security Numbers as part of the general licensing provisions. This information is exempt from public records disclosure.

NAME ____

11. LIVESCAN PRIVACY STATEMENT:

I have been provided and read the statement from the Florida Department of Law Enforcement regarding the sharing, retention, privacy and right to challenge incorrect criminal history records and the “Privacy Statement” document from the Federal Bureau of Investigation. (Found in the forms following this application). The Board will not receive your Livescan results if you do not affirm the above statement by checking this box.

12. ELECTRONIC FINGERPRINTING:

All applicants, including out-of-state and out-of-country applicants, are required to submit their fingerprints electronically. The Department of Health accepts electronic fingerprinting offered by Livescan device providers that are approved by the Florida Department of Law Enforcement. For a list of approved Livescan vendors and frequently asked questions, please visit our website at **http://www.flhealthsource.gov/background-screening/**

Typically background results submitted by Livescan are received by the Board within 24-72 hours of being processed. The Originating Agency Identification (ORI) number for the Board of Massage Therapy is: **EDOH4600Z**. The Board cannot accept hard fingerprint cards or results. All results must be submitted electronically by the Livescan service provider.

Livescan screenings done by a Florida Police or Sheriff's Department require that you login to the FDLE Civil Applicant Payment System (CAPS) at **https://caps.fdle.state.fl.us** and pay a fee before results will be released to our office.

Applicants who reside in an area where no Livescan service providers are available or because of state laws prohibiting transmission of fingerprints electronically across state lines should contact a Florida Livescan service provider who has the capability to convert a traditional card (hard card) into an electronic fingerprint card.

Because the Florida Department of Health retains fingerprints on any applicant who is required to undergo a criminal history screening as of January 1, 2013, those prints are retained in the Care Provider Clearinghouse. This Clearinghouse allows for the sharing of criminal history information among specified agencies.

One of the requirements for your Livescan to be retained in the Clearinghouse is a photograph taken by the Livescan service provider at time of fingerprinting. If your Livescan is completed without a photograph, you may have to undergo additional fingerprinting in the future.

13. APPLICANT STATEMENT

I understand that it is my duty and responsibility as an applicant for licensure to supplement my application after it has been submitted if and when any material change in circumstances or conditions occur which might affect the Board’s decision concerning my eligibility for examination or licensure. Such supplement is required by section 456.013(1), F.S. Failure to do so may result in disciplinary action by the Board including denial of licensure.

I have carefully read the questions in the foregoing application and have answered them completely, without reservation of any kind, and I declare that my answers and all statements made by me herein and in support of this application are true and correct. Should I furnish any false information on or in support of this application, I understand that such action shall constitute cause for denial, suspension, or revocation of any license to practice in the state of Florida in the profession for which I am applying. I hereby acknowledge that practice as a licensed Massage Therapist in Florida is governed by Chapters 456 and 480, F.S., and Rule Title 64B7, F.A.C. I understand that I am under a continuing obligation to understand and keep informed of any changes to Chapters 456 and 480, F.S., and Rule Title 64B7, F.A.C.

Applicant Signature: ______________________________________ **Date**: _______________

This field cannot be typed. You must print the application and sign it. MM/DD/YYYY

All applications filed with the department are valid for one (1) year from the date of receipt.

FLORIDA BOARD OF MASSAGE THERAPY LICENSE VERIFICATION REQUEST

After completion of this form, please forward this form to the licensing agency of each state by which you are now or have been licensed.

Applicant Name: ____

Address: ____

Name original license was issued under: ____

License Number: ____________________________State: __________________________________

I hereby authorize release of any information regarding my licensure status to the Florida Board of Massage Therapy.

Applicant Signature: ____ Date: __________________

STATE LICENSING AGENCY

All verifications shall be completed in English and mailed or sent electronically directly from the state(s) or jurisdiction(s) and must include the following criteria:

- □ Typed on an official state form or letterhead
- □ Include an official Board seal
- □ Signature and title of state Board official

The following information must be included in all verifications:

- □ Licensee name
- □ License number
- □ State or jurisdiction of licensure
- □ Dates of issuance/expiration
- □ Licensure method; exam type or endorsement
- □ Licensure status
- □ Is license in good standing?
- □ Has this license ever been encumbered (denied, revoked, suspended surrendered, limited, placed on probation)?

Complete verifications must be mailed or sent electronically directly from the state licensure Board to:

Florida Board of Massage Therapy
4052 Bald Cypress Way
Bin C-06
Tallahassee, FL 32399-3256

Fax (850) 412-2681
info@floridasmassagetherapy.gov

CRIMINAL CONVICTION SELF EXPLANATION FORM

This form must be completed if you answer "YES" to any of the criminal history questions on the application. Please complete a separate form for EACH offense. Duplicate this form as necessary.

Name: ____

Level of Offense (Circle One): **Felony** **Misdemeanor**

Location of Occurrence: _________________________ _____________________________
City State

Date of Offense: _________________ **Date of Sentencing:** _____________________

Offense Type (DUI, Battery, Prostitution, etc.): ____

Explanation/details surrounding the offense: What happened? What changes have you made? Attach additional sheets as necessary.

____

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____

____

Sentencing Information: Please list the details of your sentencing (I.e.: probation, jail time, fines/costs, programs completed, etc.)

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____

Current Disposition: Please list the current disposition of your sentencing.

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Don't forget to attach documentation from the Clerk of Court pertaining to the arrest/charges, sentencing due to the arrest and proof of successful completion of your sentencing.

Florida Board of Massage Therapy
Transcript Request Form

If you graduated from a massage therapy program approved by a state other than Florida, complete the top section and send this form to your Massage Therapy school to complete and attach your transcripts.

NAME ____

ADDRESS____

DATE OF BIRTH _______________

I authorize the school to release the information requested below to the Florida Board of Massage Therapy.

Signature of Student: ____________________________________ Date: ___________
MM/DD/YYYY

This section is to be completed by the Dean, Registrar, or Chairperson of the massage therapy program at the United States school from which the applicant graduated.

DO NOT complete this form in anticipation of program completion.

I hereby certify that ________________________________ successfully completed a Massage
Name of Applicant

Therapy education program at ______________________________ on _______________
School Name MM/DD/YYYY

____
Street Address State Zip Code

The curriculum completed by Applicant equals or exceeds the curriculum requirements set forth in Rule 64B7-32.003(1), F.A.C. (Attached) Hours completed: __________

The school must be approved by a governmental agency authorized to approve massage therapy programs.

______________________________________ _____________________
Name of approving agency License/certificate number

____ ________________
Printed name of Dean/Registrar/Chairperson of M.T. Program Date

____
Signature

RETURN THE ORIGINAL COMPLETED FORM, OFFICIAL STUDENT TRANSCRIPTS, AND PROOF OF SCHOOL APPROVAL DIRECTLY TO THE BOARD OFFICE.

Please mail to: Florida Board of Massage Therapy,
4052 Bald Cypress Way, Bin C06,
Tallahassee, FL 32399-3256

64B7-32.003, F.A.C. Minimum Requirements for Board Approved Massage Schools.

(1) In order to receive and maintain Board of Massage Therapy approval, a massage school, and any satellite location of a previously approved school, must:

(a) Meet the requirements of and be licensed by the Department of Education pursuant to Chapter 1005, F.S., or the equivalent licensing authority of another state or county, or be within the public school system of the State of Florida; and

(b) Offer a course of study that includes, at a minimum, the 500 classroom hours listed below, completed at the rate of no more than 6 classroom hours per day and no more than 30 classroom hours per calendar week:

Course of Study	Classroom Hours
Anatomy and Physiology	150
Basic Massage Theory and History	100
Clinical Practicum	125
Allied Modalities	76
Business	15
Theory and Practice of Hydrotherapy	15
Florida Laws and Rules (Chapters 456 and 480, F.S. and Chapter 64B7, F.A.C.)	10
Professional Ethics	4
HIV/AIDS Education	3
Medical Errors	2

Electronic Fingerprinting

Take this form with you to the Livescan service provider. Please check the service provider's requirements to see if you need to bring any additional items.

- Background screening results are obtained from the Florida Department of Law Enforcement and the Federal Bureau of Investigation by submitting to a fingerprint scan using the livescan method.
- You can find an approved Livescan Service Provider at: http://www.flhealthsource.gov/background-screening/ (*Click on Locate a Provider*)
- If you do not provide the correct Originating Agency Identification (ORI) number to the Livescan Service Provider the Board office will not receive your background screening results.
- You must provide accurate demographic information to the Livescan Service Provider at the time your fingerprints are taken, ***including your Social Security number (SSN).***
- The ORI number for the Board of Massage Therapy is **EDOH4600Z**;
- Typically background screening results submitted through a Livescan Service Provider are received by the Board within 24-72 hours of being processed.
- If you obtain your Livescan from a service provider who does not capture your photo you may be required to be reprinted by another agency in the future.

Name: ____

Aliases: ____

Date of Birth: ______________ (MM/DD/YYYY)　　Place of Birth: ______________________

Citizenship: ______________　　Race: ________　　Social Security Number: ______________

(W-White/Latino(a); B-Black; A-Asian; NA-Native American; U-Unknown)

Sex: ______ (M=Male; F=Female)　　Weight: ________　　Height: ________

Eye Color: __________　　Hair Color: ______________________

Address: ______________________________　　Apt. Number: __________

City: ______________________　　State: __________　　Zip Code: ________

Transaction Control Number (TCN#): ______________________________

(This number will be provided to you by the Live Scan Vendor.)

You will need to keep this form for your records. Do not send this form to the Board Office.

FLORIDA DEPARTMENT OF LAW ENFORCEMENT

NOTICE FOR APPLICANTS SUBMITTING FINGERPRINTS WHERE CRIMINAL RECORD RESULTS WILL BECOME PART OF THE CARE PROVIDER BACKGROUND SCREENING CLEARINGHOUSE

NOTICE OF:

- **SHARING OF CRIMINAL HISTORY RECORD INFORMATION WITH SPECIFIED AGENCIES,**
- **RETENTION OF FINGERPRINTS,**
- **PRIVACY POLICY, AND**
- **RIGHT TO CHALLENGE AN INCORRECT CRIMINAL HISTORY RECORD**

This notice is to inform you that when you submit a set of fingerprints to the Florida Department of Law Enforcement (FDLE) for the purpose of conducting a search for any Florida and national criminal history records that may pertain to you, the results of that search will be returned to the Care Provider Background Screening Clearinghouse. By submitting fingerprints, you are authorizing the dissemination of any state and national criminal history record that may pertain to you to the Specified Agency or Agencies from which you are seeking approval to be employed, licensed, work under contract, or to serve as a volunteer, pursuant to the National Child Protection Act of 1993, as amended, and Section 943.0542, Florida Statutes. "Specified agency" means the Department of Health, the Department of Children and Family Services, the Division of Vocational Rehabilitation within the Department of Education, the Agency for Health Care Administration, the Department of Elder Affairs, the Department of Juvenile Justice, and the Agency for Persons with Disabilities when these agencies are conducting state and national criminal history background screening on persons who provide care for children or persons who are elderly or disabled. The fingerprints submitted will be retained by FDLE and the Clearinghouse will be notified if FDLE receives Florida arrest information on you.

Your Social Security Number (SSN) is needed to keep records accurate because other people may have the same name and birth date. Disclosure of your SSN is imperative for the performance of the Clearinghouse agencies' duties in distinguishing your identity from that of other persons whose identification information may be the same as or similar to yours.
Licensing and employing agencies are allowed to release a copy of the state and national criminal record information to a person who requests a copy of his or her own record if the identification of the record was based on submission of the person's fingerprints. Therefore, if you wish to review your record, you may request that the agency that is screening the record provide you with a copy. After you have reviewed the criminal history record, if you believe it is incomplete or inaccurate, you may conduct a personal review as provided in s. 943.056, F.S., and Rule 11C-8.001, F.A.C. If national information is believed to be in error, the FBI should be contacted at 304-625-2000. You can receive any national criminal history record that may pertain to you directly from the FBI, pursuant to 28 CFR Sections 16.30-16.34. You have the right to obtain a prompt determination as to the validity of your challenge before a final decision is made about your status as an employee, volunteer, contractor, or subcontractor.

Until the criminal history background check is completed, you may be denied unsupervised access to children, the elderly, or persons with disabilities.

The FBI's Privacy Statement follows on a separate page and contains additional information.

US Department of Justice
Federal Bureau of Investigation
Criminal Justice Information Services Division

PRIVACY STATEMENT

Authority: The FBI's acquisition, preservation and exchange of information requested by this form is generally authorized under 28 U.S.C. 534. Depending on the nature of your application, supplemental authorities include numerous Federal statutes, hundreds of State statutes pursuant to Pub.L.92-544, Presidential executive orders, regulations and/or orders of the Attorney General of the United States, or other authorized authorities. Examples include, but are not limited to: 5 U.S.C. 9101; Pub.L.94-29; Pub.L.101-604; and Executive Orders 10450 and 12968. Providing the requested information is voluntary; however, failure to furnish the information may affect timely completion of approval of your application.

Social Security Account Number (SSAN). Your SSAN is needed to keep records accurate because other people may have the same name and birth date. Pursuant to the Federal Privacy Act of 1974 (5 USC 552a), the requesting agency is responsible for informing you whether disclosure is mandatory or voluntary, by what statutory or other authority your SSAN is solicited, and what uses will be made of it. Executive Order 9397 also asks Federal Agencies to use this number to help identify individuals in agency records.

Principal Purpose: Certain determinations, such as employment, security, licensing and adoption, may be predicated on fingerprint based checks. Your fingerprints and other information contained on (and along with) this form may be submitted to the requesting agency, the agency conducting the application investigation, and/or FBI for the purpose of comparing the submitted information to available records in order to identify other information that may be pertinent to the application. During the processing of this application, and for as long hereafter as my be relevant to the activity for which this application is being submitted, the FBI(may disclose any potentially pertinent information to the requesting agency and/or to the agency conducting the investigation. The FBI may also retain the submitted information in the FBI's permanent collection of fingerprints and related information, where it will be subject to comparisons against other submissions received by the FBI. Depending on the nature of your application, the requesting agency and/or the agency conducting the application investigation may also retain the fingerprints and other submitted information for other authorized purposes of such agency(ies).

Routine Uses: The fingerprints and information reported on this form may be disclosed pursuant to your consent, and may also be disclosed by the FBI without your consent as permitted by the Federal Privacy Act of 1974 (5 USC 552a(b)) and all applicable routine uses as many be published at any time in the Federal Register, including the routine uses for the FBI Fingerprint Identification Records System (Justice,FBI-009) and the FBI's Blanket Routine Uses (Justice/FBI-BRU). Routine uses include, but are not limited to, disclosures to: appropriate governmental authorities responsible for civil or criminal law enforcement counterintelligence, national security or public safety matters to which the information may be relevant; to State and local governmental agencies and nongovernmental entities for application processing as authorized by Federal and State legislation, executive order, or regulation, including employment, security, licensing, and adoption checks; and as otherwise authorized by law , treaty, executive order, regulation, or other lawful authority. If other agencies are involved in processing the application, they may have additional routine uses.

Additional Information: The requesting agency and/or the agency conducting the application investigation will provide you additional information pertinent to the specific circumstances of this application, which may include identification of other authorities, purposes, uses, and consequences of not providing requested information. In addition, any such agency in the Federal Executive Branch has also published notice.