Massage Therapist Licensure Application

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

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

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: ______________________________ ____________________________ ____________ **Date of Birth:** _____________
Last/Surname First Middle 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 address will be posted on the Department of Health'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 the following information as part of your voluntary compliance with Section 2, Uniform Guidelines on Employee Selection Procedure (1978) 43 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 ☐ Black ☐ Asian/Pacific Islander ☐ Hispanic ☐ Other _____________

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 PROGRAM ATTENDED: ____

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 **Attach additional sheets, if necessary**

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. MANDATORY FLORIDA EDUCATION REQUIREMENT

Completion of a two (2) hour course on Prevention of Medical Errors, a ten (10) hour course on Florida Laws and Rules and a three (3) hour course on HIV/AIDS is required prior to licensure. These courses must be from an approved Florida Board of Massage Therapy provider or massage school. (If you graduated from a Florida approved massage school you may check Yes.)

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

If you checked NO, please submit your course certificates to the Board office upon completion.

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**.
- Three (3) current (written within the last year) professional **Letters of Recommendation**.

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

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?

B. ☐ 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?

C. ☐ 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?

NAME ______________________________

6. CRIMINAL HISTORY

Answers to commonly asked questions can be found on our website at: **http://www.floridasmassagetherapy.gov/help-center/#faqs**

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.
- Three (3) current (written within the last year) professional **Letters of Recommendation**.

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 address below. 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?

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?

6. ☐ Yes ☐ No **If "Yes" to any of the questions 1 through 5 above,** on or before July 1, 2009, were you enrolled in an educational or training program in the profession in which you are seeking licensure that was recognized by the Board of Massage Therapy or Department of Health? **(If "Yes", please provide official documentation verifying your enrollment status.)**

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. ADDITIONAL INFORMATION

☐ Yes ☐ No **Availability for Disaster:** 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?

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 that occurred within the past five years?

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 within the past five years?

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 within the last five years?

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 within the past five years?

Name: ____

Last **First** **Middle**

Social Security Number: ______________________________

* This page is exempt from public records disclosure. The Department of Health is required and authorized to collect Social Security Numbers relating to applications for professional licensure pursuant to Title 42 USCA § 666 (a)(13). For all professions regulated under Chapter 456, Florida Statutes, the collection of Social Security Numbers is required by section 456.013 (1)(a), Florida Statutes.

Social Security Information - * Under the Federal Privacy Act, disclosure of Social Security numbers is voluntary unless specifically required by federal statute. In this instance, Social Security numbers are mandatory pursuant to Title 42 United States Code, Sections 653 and 654; and Section 456.013(1), 409.2577 and 409.2598, Florida Statutes. Social Security numbers are used to allow efficient screening of applicants and licensees by a Title IV-D child support agency to ensure compliance with child support obligations. Social Security numbers must also be recorded on all professional and occupational license applications and will be used for license identification pursuant to the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Welfare Reform Act. 104 Pub.L. Section 317) Clarification of the SSA process may be reviewed at **www.ssa.gov** or by calling 1-800-772-1213.

NAME ____

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 Chapter 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 Chapter 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: ____ SSN: _____________________

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: ____

Social Security Number: ____

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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____

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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____

SOCIAL SECURITY # _______________________ 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 chapter 64B7-32.003 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	10
(Chapters 456 and 480, F.S. and Chapter 64B7, F.A.C.)	
Professional Ethics	4
HIV/AIDS Education	3
Medical Errors	2