

FLORIDA BOARD OF MASSAGE THERAPY LICENSE VERIFICATION REQUEST

PART I: TO BE COMPLETED BY APPLICANT

Send to all state(s) of licensure (not Florida). Make Copies as necessary.

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: _____

PART II: 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 to or sent electronically directly from the official state licensure Board to:

**Florida Board of Massage Therapy
4052 Bald Cypress Way
Bin C06
Tallahassee, FL 32399-3256**

**Fax (850) 412-2681
MQA.MassageTherapy@flhealth.gov**