

# Application for Massage Therapist License by Examination



**Board of Massage Therapy**  
**P.O. BOX 6330**  
**Tallahassee, FL 32314-6330**  
**Website: <https://floridasmassagetherapy.gov/>**  
**Email: [MQA.MassageTherapy@flhealth.gov](mailto:MQA.MassageTherapy@flhealth.gov)**  
**Phone: (850) 245-4161**  
**Fax: (850) 412-2681**





**Are you an active-duty member of the United States Armed Services?**

**Are you a veteran of the United States Armed Services?**

**Are you the spouse of a veteran of the United States Armed Services?**

**Are you the spouse of an active member of the United States Armed Services?**

If you answered “Yes” to any of these questions, you may qualify for a reduction in your application fees. You can find information about the Florida Department of Health’s commitment to serving members and veterans of the United States Armed Forces and their families online at

<http://www.flhealthsource.gov/valor>.



# Application for Massage Therapist License by Examination

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P.O. Box 6330  
Tallahassee, FL 32314-6330  
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Email: [MQA.MassageTherapy@flhealth.gov](mailto:MQA.MassageTherapy@flhealth.gov)

Do Not Write in this Space  
For Revenue Receiving Only

Applicants must be at least 18 years of age or have received a high school diploma or graduate equivalency diploma.

**Massage Therapist by Examination (1021) \$155.00 –**  
For applicants who are not licensed in another state, territory, or jurisdiction, OR whose license was issued based on education which is not equivalent to education required in Florida.

<b>Total fee of \$155.00 includes the following:</b>	
Application Fee (non-refundable)	\$50.00
Initial Licensure Fee (refundable)	\$100.00
Unlicensed Activity Fee (refundable)	\$5.00

**Important Note:** If you hold an active license in another state, territory, or jurisdiction which has education requirements for licensure which meet or exceed those required in Florida, do not submit this application, and instead submit the application by Endorsement.

Fees must be paid in the form of a cashier's check or money order, made payable to the Department of Health. An applicant who is denied licensure or withdraws their application is entitled to a \$105.00 (Licensure Fee and Unlicensed Activity Fee) refund. Requests to withdraw or for a refund must be made in writing. Fees are refundable for up to three 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/P.O. Box Apt. No. City  
\_\_\_\_\_  
State ZIP Country Home/Cell Telephone

Physical Location: (Required if mailing address is a P.O. Box- This address will be posted on the Department of Health's website.)

\_\_\_\_\_  
Street (Place of Employment) Suite No. City  
\_\_\_\_\_  
State ZIP Country Work/Cell Telephone

### EQUAL OPPORTUNITY DATA:

We are required to ask that you furnish the following information as part of your voluntary compliance with 41 CFR Part 60-3-Uniform Guidelines on Employee Selection Procedure (1978); 43 FR 38295 and 38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

Gender: Male Race: Native Hawaiian or Pacific Islander Hispanic or Latino White  
Female American Indian or Alaska Native Black or African American Asian  
Two or More Races

**Email Notification:** To be notified of the status of your application by email, check the "Yes" box and fill in your email address on the line provided. If you choose to be notified via email you will be responsible for checking your email regularly and updating your email address with the board office.

Yes No Email Address: \_\_\_\_\_

Under Florida law, email addresses are public records. If you do not want your email 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.

## 2. SOCIAL SECURITY DISCLOSURE

**This information is exempt from public records disclosure.**

Pursuant to Title 42 United States Code § 666(a)(13), the department is required and authorized to collect Social Security numbers relating to applications for professional licensure. Additionally, section (s.) 456.013(1)(a), Florida Statutes, authorizes the collection of Social Security numbers as part of the general licensing provisions.

**Last Name:** \_\_\_\_\_

**First Name:** \_\_\_\_\_

**Middle Name:** \_\_\_\_\_

**U.S. Social Security Number:** \_\_\_\_\_

**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 § 653 and 654; and s. 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 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](http://www.ssa.gov) or by calling 1-800-772-1213.

***You may apply for a license before obtaining a Social Security number. However, you will not be issued a license until proof of a U.S. Social Security number is received.***

Board of Massage Therapy  
4052 Bald Cypress Way Bin C-06  
Tallahassee, FL 32399-3257

Name: \_\_\_\_\_

**3. APPLICANT BACKGROUND**

A. List any other name(s) by which you have been known in the past. Attach additional sheets if necessary.

\_\_\_\_\_

B. Do you hold, or have you ever held a license to practice massage therapy or any other health-related license(s)?            Yes            No

C. List all health-related licenses (active, inactive, or lapsed).

License Type	License #	State/Country	Original Date Issued (MM/DD/YYYY)	Expiration Date (MM/DD/YYYY)	Status of License

**If you listed any licenses above, you may be required to submit a license verification.** Board staff will attempt to verify your license(s) using available primary-source information (i.e. online verifications). If verification is not available, you will be notified in writing that official license verification(s) are required.

D. Have you ever been issued a cease and desist or citation for the unlicensed practice of massage therapy or for operating a massage establishment without a license in Florida, or had similar action taken against you in another state, territory, or jurisdiction for unlicensed practice of massage therapy or unlicensed operation of a massage establishment?            Yes            No

**If you responded "Yes," provide the following:**

**Documentation of the occurrence**, including any relevant criminal or administrative filings. This documentation must demonstrate resolution of the incident.

E. Have you ever been the defendant in a civil litigation in which the basis of the complaint against you was alleged negligence, malpractice, sexual misconduct, or fraud?            Yes            No

**If you responded "Yes" provide the following:**

**A written self-explanation** for each civil litigation.

**Supporting documentation** including the court records for the civil litigation.

**Documentation must be sent to the board office at [MQA.MassageTherapy@flhealth.gov](mailto:MQA.MassageTherapy@flhealth.gov), or mailed to:**

Board of Massage Therapy  
4052 Bald Cypress Way Bin C-06  
Tallahassee, FL 32399-3257

**4. AVAILABILITY FOR DISASTER**

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

If you respond "Yes," your name will be added to a listing that is available to the Department of Health if a disaster is declared. If you live in an area where you may be able to help you will be called on if needed.

Name: \_\_\_\_\_

**5. EDUCATION HISTORY**

A. List the massage therapy school you attended.

School Name	School State or Country	Graduation Date (MM/DD/YYYY)

**All applicants must submit proof of graduation.**

**For graduates from Florida board approved massage therapy schools who use graduate lists, this requirement will be met when the board office receives a graduate list from your school.** If you are unsure whether your school submits graduate lists, contact the school directly.

<b>If you attended a Florida board approved massage therapy school which submits graduate lists:</b>
I authorize the school listed above to release my proof of graduation via graduate list.

**All other applicants must have an official transcript forwarded directly to the board office from your school which shows successful completion of a course of study in massage therapy. Diplomas and student copies are not acceptable. Transcripts must be sent to:**

**Board of Massage Therapy**  
 4052 Bald Cypress Way Bin C-06  
 Tallahassee, FL 32399-3257

**If you completed your course of study at a school in another state, you may be required to submit additional information concerning the licensing of your massage program.** Board staff will attempt to verify this information using primary-source information. If verification is not available, you will be notified in writing.

**If you completed your course of study outside the United States,** you will need to have your transcripts translated and evaluated by an education credentialing service.

B. Successful completion of a 10-hour Florida Laws and Rules course for massage therapists which covers ch. 480 and 456, Florida Statutes, and Rule Title 64B7, Florida Administrative Code (F.A.C.) is **required prior to licensure**. This course must be from a Florida Board of Massage Therapy approved continuing education provider or board approved massage therapy school. A complete listing of available courses and providers is available at [www.cebroke.com](http://www.cebroke.com).

**I completed the required 10-hour Florida Laws and Rules course** as part of a course of study at a Florida board approved massage therapy school, or as a continuing education course with a Florida board approved continuing education provider or school.

**I have NOT completed the required 10-hour Florida Laws and Rules course.**

**Applicants who have not completed the course must complete the course and submit a certificate of completion before a license may be issued. Certificates may be submitted by email to [MQA.MassageTherapy@flhealth.gov](mailto:MQA.MassageTherapy@flhealth.gov) or mailed to:**

**Board of Massage Therapy**  
 4052 Bald Cypress Way Bin C-06  
 Tallahassee, FL 32399-3257

Name: \_\_\_\_\_

## 6. EXAMINATION HISTORY

Successful completion of an approved examination is required for licensure. The examinations listed below are currently approved for licensure.

<b>Examination Taken (choose all that apply):</b>	<b>Date (MM/DD/YYYY)</b>
<b>MBLEx</b> (Massage and Bodywork Licensing Examination)	
<b>NCBTMB or NCETM</b> (National Certification Examination for Therapeutic Massage and Bodywork)	
<b>NESL</b> (National Exam for State License)	
<b>Florida State Board Examination</b> (pre-1996)	
<b>Other</b> (specify): _____	
<b>I have not taken an approved examination.</b>	

If you have not taken one of the approved examinations, you will need to take an approved examination before a license can be issued. The Massage and Bodywork Licensing Examination (MBLEx), administered by the Federation of State Massage Therapy Boards is currently offered and meets this requirement. For information about the MBLEx, including registration and candidate eligibility information, visit [www.fsmtb.org](http://www.fsmtb.org).

**Applicants must have a passing examination result sent directly from the testing provider.**

***Board staff cannot request examination results on your behalf. Examination results submitted by applicants (uploaded, emailed, mailed) will not be accepted.***



**This information is exempt from public records disclosure.**

## 7. HEALTH HISTORY

The board and the department, as part of its responsibility to protect the health, safety, and welfare of the public, must assess whether an applicant manifests any physical, mental health, or substance use issue that impairs the applicant's ability to meet the eligibility requirements for a health care practitioner as defined in chapter (ch.) 456, Florida Statutes, and the applicable statutory practice acts.

The board and the department support applicants seeking treatment and views effective treatment by a licensed professional as enhancing the applicant's ability to meet the eligibility requirements to practice a health care profession.

Seeking assistance with stress, mild anxiety, situational depression, family or marital issues will not adversely affect the outcome of a Florida health care practitioner application. The board and the department do not request that applicants disclose such assistance.

1. During the last two years, have you been treated for or had a recurrence of a diagnosed physical or mental disorder that impaired or impairs your ability to practice?      Yes      No
2. During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol or drug) disorder that impaired or impairs your ability to practice?      Yes      No

**If a "Yes" response was provided** to any of the questions in this section, provide the following documents directly to the board office:

**A letter from a licensed health care practitioner**, who is qualified by skill and training to address the condition identified, which explains the impact the condition may have on the ability to practice the profession with reasonable skill and safety. The letter must specify that the applicant is safe to practice the profession without restrictions or specifically indicate the restrictions that are necessary. Documentation provided must be dated within one year of the application date.

**A written self-explanation**, identifying the medical condition(s) or occurrence(s); and current status.



Name: \_\_\_\_\_

**8. DISCIPLINE HISTORY**

- A. Have you ever been denied or is there now any proceeding to deny your application for any health care license to practice in Florida or any other state, jurisdiction, or country?      Yes      No
- B. Have you ever had any professional license or license to practice revoked, suspended, placed on probation, or received a disciplinary action taken in any state, territory, or country?      Yes      No
- C. Have you ever surrendered a license to practice any health care related profession in Florida or any other state, jurisdiction, or country while any such disciplinary charges were pending against you?      Yes      No
- D. Do you have any disciplinary action pending against any health care related license you currently hold or have held in the past?      Yes      No

**If you responded “Yes” to questions in this section, complete the following:**

Name of Agency	State	Action Date (MM/DD/YYYY)	Final Action	Under Appeal?
				Y    N
				Y    N
				Y    N

**If you responded “Yes” to questions in this section, you must provide the following:**

**A written self-explanation**, describing in detail the circumstances surrounding the disciplinary action.

A copy of the **Administrative Complaint** and **Final Order**.

**9. CRIMINAL HISTORY**

Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to any crime in any jurisdiction other than a minor traffic offense? You must include all misdemeanors and felonies, even if adjudication was withheld. Pursuant to s. 943.0585(6)(b), Florida Statutes, and s. 943.059(6)(b), Florida Statutes, an applicant seeking to be licensed by the Department of Health must disclose expunged and sealed criminal history records.

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.      Yes      No

**If you responded “Yes” in this section, complete the following:**

Offense	Jurisdiction	Date (MM/DD/YYYY)	Final Disposition	Under Appeal?
				Y    N
				Y    N
				Y    N

**If you responded “Yes,” you must provide the following:**

**A written self-explanation**, describing in detail the circumstances surrounding each offense; including date, 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 documents from the Department of Corrections. The report must include the start date, end date, and that the conditions were met.

## 10. CRIMINAL AND MEDICAID / MEDICARE FRAUD QUESTIONS

**IMPORTANT NOTICE:** Applicants for licensure, certification, or registration and candidates for examination may be excluded from licensure, certification, or registration if their felony convictions fall into certain timeframes as established in s. 456.0635(2), Florida Statutes.

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

**If you responded “No” to the question above, skip to question 2.**

- a. If “Yes” to 1, for the felonies of the first or second degree, has it been more than 15 years from the date of the plea, sentence, and completion of any subsequent probation?      Yes      No
  - b. If “Yes” to 1, for the felonies of the third degree, has it been more than 10 years from the date of the plea, sentence, and completion of subsequent probation (this question does not apply to felonies of the third degree under s. 893.13(6)(a), Florida Statutes)?      Yes      No
  - c. If “Yes” to 1, for the felonies of the third degree under s. 893.13(6)(a), Florida Statutes, has it been more than five years from the date of the plea, sentence, and completion of any subsequent probation?  
Yes      No
  - d. If “Yes” to 1, have you successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or the charges dismissed (if “Yes,” provide supporting documentation)?  
Yes      No
2. Have you been convicted of, or entered a plea of guilty or nolo contendere, regardless of adjudication, to 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)?      Yes      No

**If you responded “No” to the question above, skip to question 3.**

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

**If you responded “No” to the question above, skip to question 4.**

- a. If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years?      Yes      No
4. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program?      Yes      No

**If you responded “No” to the question above, skip to question 5.**

- a. Have you been in good standing with a state Medicaid program for the most recent five years?  
Yes      No
- b. Did termination occur at least 20 years before the date of this application?      Yes      No

Name: \_\_\_\_\_

5. Are you currently listed on the United States Department of Health and Human Services' Office of the Inspector General's List of Excluded Individuals and Entities (LEIE)?      Yes      No
- a. If you responded "Yes" to the question above, are you listed because you defaulted or are delinquent on a student loan?      Yes      No
- b. If you responded "Yes" to question 5.a., is the student loan default or delinquency the only reason you are listed on the LEIE?      Yes      No

**If you responded "Yes" to any of the questions in this section, you must provide the following:**

**A written self-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.

**Supporting documentation** including court dispositions or agency orders where applicable.

**Documentation for sections 7 and 8 must be sent to the board office at**  
[MOA.MassageTherapy@flhealth.gov](mailto:MOA.MassageTherapy@flhealth.gov)  
**or mailed to:**

**Board of Massage Therapy**  
4052 Bald Cypress Way Bin C-06  
Tallahassee, FL 32399-3257

**Documentation for sections 9 and 10 must be sent to**  
[MOA.BackgroundScreen@flhealth.gov](mailto:MOA.BackgroundScreen@flhealth.gov) **or**  
**mailed to:**

**Background Screening Unit**  
**Florida Department of Health**  
4052 Bald Cypress Way, Bin BSU-01  
Tallahassee, FL 32399

## 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 confirm the above statement by checking the box.**

### **Electronic Fingerprinting: (Required for ALL applicants)**

All applicants, including out-of-state applicants, are required to submit their fingerprints electronically. The Department of Health accepts electronic fingerprinting offered by Livescan service providers that are approved by the Florida Department of Law Enforcement. For a list of approved vendors, 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 board's ORI number is **EDOH4600Z**. The board cannot accept hard fingerprint cards or results. All results must be submitted electronically by the Livescan service provider.

Fingerprints taken for the Florida Department of Health are retained in the Care Provider Clearinghouse. One of the requirements for your Livescan to be retained in the Care Provider Clearinghouse is a photograph taken by the Livescan service provider at the time of fingerprinting. Your background screening results will be retained for five years. Licensees will be notified when their retention date is approaching and will be provided with instructions on how to retain their fingerprints to avoid having to submit a new background screening.

Name: \_\_\_\_\_

## 12. APPLICANT SIGNATURE

I, the undersigned, state that I am the person referred to in this application for licensure in the state of Florida.

I recognize that providing false information may result in disciplinary action against my license or criminal penalties pursuant to s. 456.067, Florida Statutes.

I have carefully read the questions in the 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.

Florida law requires me to immediately inform the board of any material change in any circumstances or condition stated in the application which takes place between the initial filing and the final granting or denial of the license and to supplement the information on this application as needed.

Section 456.013(1)(a), Florida Statutes., provides that an incomplete application shall expire one year after the initial filing with the department.

Applicant Signature \_\_\_\_\_ Date \_\_\_\_\_  
*You may print this application and sign it or sign digitally.* MM/DD/YYYY

## FLORIDA DEPARTMENT OF LAW ENFORCEMENT

NOTICE FOR ALL APPLICANTS SUBMITTING FINGERPRINTS WHERE CRIMINAL RECORDS 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 to be employed, licensed, work under contract, or 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 Person 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 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 your 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, Florida Statutes, 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.**

## 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 may 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, disclosure 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 additional information 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.

# Board of Massage Therapy Electronic Fingerprinting



Take this form with you to the Livescan service provider. 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 a fingerprint scan using the Livescan method.
- You can find Livescan service providers at: <http://www.flhealthsource.gov/background-screening>.
- Failure to submit background screening will delay your application.
- Applicants may use any Livescan service provider approved by the Florida Department of Law Enforcement to submit their background screening to the department.
- 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.
- The ORI number for the Board of Massage Therapy is **EDOH4600Z**.
- You must provide accurate demographic information to the Livescan service provider at the time your fingerprints are taken, **including your Social Security number (SSN)**.
- 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: \_\_\_\_\_ SSN#: \_\_\_\_\_  
Last First Middle

Aliases: \_\_\_\_\_

Address: \_\_\_\_\_ Apt. Number: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_  
MM/DD/YYYY

Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Eye Color: \_\_\_\_\_ Hair Color: \_\_\_\_\_

Race: \_\_\_\_\_ Sex: \_\_\_\_\_  
(W-White/Latino(a); B-Black; A- Asian; NA-Native American; U-Unknown) (M= Male; F=Female)

Citizenship: \_\_\_\_\_

Transaction Control Number (TCN#): \_\_\_\_\_  
(This will be provided to you by the Livescan service provider.)

**Keep this form for your records.**



**Complete verifications must be sent directly from the education program to the board office at:**

**Board of Massage Therapy**  
4052 Bald Cypress Way Bin C-06  
Tallahassee, FL 32399-3257



## Board of Massage Therapy Transcript Request

If you graduated from a massage therapy program approved by a state other than Florida, complete Part I and send this form to your massage therapy school to complete and attach your transcripts.

### Part I: To be completed by applicant

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

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

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
MM/DD/YYYY

### Part II: 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 Therapy education program  
Name of Applicant

at \_\_\_\_\_ on \_\_\_\_\_.  
School Name MM/DD/YYYY

Street Address City State ZIP

The curriculum completed by the applicant equals or exceeds the curriculum requirements set form in Rule 64B7-32.003(1), Florida Administrative Code (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 Massage Therapy Program Date (MM/DD/YYYY)

Signature

**Return the original completed form, official transcript, and proof of school approval directly to the board office.**

# Board of Massage Therapy Transcript Request Attachment



## **Rule 64B7-32.003, Florida Administrative Code (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, Florida Statutes (F.S.), or the equivalent licensing authority or 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 six classroom hours per day and no more than 30 classroom hours per calendar week:

<b>Course of Study</b>	<b>Classroom Hours</b>
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 Rule 64B7, F.A.C.) Professional Ethics	4
HIV/AIDS Education	3
Medical Errors	2
<b>Total</b>	<b>500</b>

Complete verifications must be sent directly from the licensing agency to the board office at [MQA.MassageTherapy@flhealth.gov](mailto:MQA.MassageTherapy@flhealth.gov), or mailed to:

Board of Massage Therapy  
4052 Bald Cypress Way Bin C-06  
Tallahassee, FL 32399-3257



## Board of Massage Therapy License Verification Request

**Part I: To be completed by applicant** (Florida requires verification of all your current and previously held licenses.)

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 Massage Therapy.*

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
MM/DD/YYYY

## Part II: To be completed by state licensing agency

All verifications must be in English and 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
- \* Licensure status
- \* Date of issuance/expiration
- \* Licensure method (examination or reciprocity/endorsement)
- \* Has this license ever been encumbered (denied, revoked, suspended, surrendered, limited, placed on probation)?
- \* If this license has ever been encumbered, please provide certified copies of documentation regarding the action with the completed license verification.
- \* License number
- \* Is license in good standing?
- \* State or jurisdiction of licensure