



# State Medical Board of Ohio

30 E. Broad St., 3rd Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: <http://med.ohio.gov/>

RE: Massage Therapy

Dear Applicant:

Attached is an application and instructions for the Massage Therapy Examination. **PLEASE READ THE INSTRUCTIONS THOROUGHLY BEFORE COMPLETING THE APPLICATION.** You must complete the entire application and submit all required documentation.

Please note that once submitted an application cannot be withdrawn without the approval of the Board. Fees submitted are neither refundable nor transferable, even if a withdrawal is permitted.

It is important you understand that **under Ohio law no provisions exist for temporary or provisional licensure while your request for licensure is being processed. The practice of massage therapy prior to licensure constitutes a criminal offense.**

All applicants applying to sit for the **DECEMBER 1, 2009** Massage Therapy examination in Ohio **must submit** the completed application **and** application fee no later than the posted deadline date.

**THE COMPLETED APPLICATION AND FEE MUST BE RECEIVED IN THE BOARD OFFICES NO LATER THAN SEPTEMBER 1, 2009.**

**APPLICATIONS SUBMITTED WITHOUT THE FEE AND/OR RECEIVED AFTER THE DEADLINE WILL NOT BE ACCEPTED.**

Any applicant failing to comply with the above-mentioned instructions will not be allowed to sit for the Massage Therapy examination in Ohio under any circumstances.

Attachments:

## MASSAGE THERAPY APPLICATION INSTRUCTIONS

Review the following instructions and the entire application packet carefully before completing the application. Processing will not begin until the appropriate fee is received. Failure to submit all required information and documentation will result in processing delays.

1. Fill out the enclosed **APPLICATION FOR CERTIFICATE – MASSAGE THERAPY** in its entirety. You must provide a response to each section or question of the application as instructed. Mark "N/A" if Not Applicable.
2. Submit a check or money order in the amount of **\$250.00** made payable to the **Kevin L. Boyce, Ohio Treasurer**, with your completed application. **FEES SUBMITTED ARE NEITHER REFUNDABLE NOR TRANSFERABLE.**
3. Request a criminal records check from the Ohio BCII and FBI (refer to the Criminal Records Check instruction sheet for additional information).
4. Attach a recent (taken within the last six months) passport-type **COLOR** photo to each of the two Certificates of Recommendation (Form 1), sign and date beneath your photographs, and forward to two residents of the state in which you are residing who will complete these recommendations. The residents you choose to complete each form must have known you at least six months. Relatives may not serve as recommenders. Black and white photos will not be accepted.
5. Enclose a photocopy of your massage therapy diploma. ***(Please note that if you have not yet graduated your school will forward a copy of your diploma to the Board)***
5. Forward the enclosed Certificate of Education (Form 2) to the school where you completed your massage therapy training. This form must be completed by the President, Dean or Secretary of the school of graduation. This form is not to be completed **prior** to graduation. ***(Please note that if you have not yet graduated your school will forward the Form 2 to the Board)***
6. If you have changed your name, since receiving your preliminary education number, you must submit a photocopy of the appropriate legal document which authorizes each name change. This may be a court decree and/or a marriage certificate. Any document in a foreign language must be accompanied by an official, certified translation.
7. Mail your completed application and fee directly to the Ohio Board at the following address:

State Medical Board of Ohio  
30 E. Broad Street, 3rd Floor  
Columbus, OH 43215-6127

<b>THE COMPLETED APPLICATION <u>AND</u> FEE MUST BE RECEIVED IN THE BOARD OFFICES <u>NO LATER THAN SEPTEMBER 1, 2009.</u></b>
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## **American's with Disabilities Act of 1990 (ADA)**

Under the ADA the Board will provide accommodations to exam applicants diagnosed with a disability. Applicants will be required to submit documentation of their disability, including medical documentation and if any accommodations were granted in the past. An applicant must notify the Board no later than the final application deadline that he/she has a disabling condition and is requesting special testing accommodations. To accelerate the review process, applicants are urged to submit their request and supporting documentation as early in the application process as possible.

## **Application Process**

The State Medical Board processes hundreds of applications for each examination. Applications are processed in the order in which they are received. An incomplete application or any unusual circumstances discovered during processing will result in a delay. You will be notified if the application is incomplete or contains errors.

## **Additional Information Section**

Please keep a copy of the Additional Information Questions for your own reference. If any answers to these questions change while your application is pending, you must notify the State Medical Board in writing.

## **Admission to the Examination**

Notification of specific dates, times and places will be furnished not less than thirty days in advance. An incomplete application or any unusual circumstances discovered during processing will result in deviation from this schedule. If you are unable to sit for the examination you must notify the Board in writing, including the reason why you are unable to take the examination, as soon as possible.

## **Examination Results**

Results of the examination are tentatively scheduled for release approximately 2 months after the administration of the examination. Applicants will be notified by mail of the examination results. Applicants who do not pass the examination will be mailed an application to reapply for the next examination.

## **Licensure Letter, Wallet Card and Wall Certificate**

Upon issuance of an Ohio license number, a letter of notification will be sent to you. That letter will serve as legal authorization to practice in Ohio. A wallet card and wall certificate will be mailed approximately one month after licensure. Hospitals, insurance companies, etc., must obtain verification of your Ohio license directly from the Board's website. The Ohio Medical Board website address is <http://med.ohio.gov> in the "Licensee Profile and Status section. The website is updated immediately to reflect newly issued licenses.

## **Display of Wall Certificate**

The wall certificate, by law, must be displayed in your office or the place where a major portion of your practice is conducted.

## **Renewal**

Ohio law requires Massage Therapists to register (renew) licenses every two years, by August 31st of every odd numbered year. Applications are mailed approximately May 1st of each odd numbered year. Individuals who are initially licensed after the date of renewal application mailing will not be required to register or pay the registration fee, but individuals licensed prior to that date will be required to register and pay the applicable fee.

**CRIMINAL RECORDS CHECK REQUIRED FOR INITIAL LICENSURE**  
**MESSAGE THERAPIST (LMT)**  
**COSMETIC THERAPIST(CT)**

Chapter 4731 of the Ohio Revised Code requires all individuals applying for an initial license with the State Medical Board of Ohio to submit fingerprints for a criminal records check completed by the Ohio Bureau of Criminal Identification and Investigation (BCII) and the Federal Bureau of Investigation (FBI).

**Instructions for Individuals Residing in Ohio**

Applicants residing in Ohio are required to utilize “WebCheck,” Ohio’s electronic fingerprint system, to electronically submit their fingerprints to BCII. The Board will typically receive the results of criminal records check submitted via “WebCheck” within 7 to 10 business days. In addition to the BCII fee and FBI fee, the electronic fingerprinting company/agency may charge a handling fee to process the fingerprints.

Since the law requires applicants for licensure to submit a criminal records check completed by both BCII and the FBI, applicants **MUST** use the services of a vendor that participates in the “WebCheck.” The Sheriff’s offices in all 88 Ohio counties participate in the “National WebCheck.” A list of all vendors, searchable by county, is available online at:

<http://www.ohioattorneygeneral.gov/Services/Business/WebCheck>

**When locating an electronic fingerprinting site on this web page, please note that you **MUST** use the services of a vendor that has (BCII and FBI) listed after the vendor’s name.** Only these entities participate in “National WebCheck”. The Board does not endorse or recommend any specific electronic fingerprinting company/agency.

**You need both the BCII and FBI criminal records check for initial licensure. By law, the Board cannot complete the processing of your application until it receives the background check reports from both BCII and FBI.**

**Steps for “National WebCheck”**

- Identify a “**BCI and FBI**” vendor that participates in the “National WebCheck”.
- Submit your fee directly to the vendor. **DO NOT SEND YOUR FINGERPRINTS OR FEE TO THE BOARD.**
- Request that the criminal records check results from both BCII and FBI be sent directly to:

**State Medical Board of Ohio  
30 E. Broad St., 3<sup>rd</sup> Floor  
Columbus, Ohio 43215-6127**

- Indicate the reason for fingerprinting as “Required for licensure per ORC 4731.171”.
- List the agency code as **1AB002**.

**Instructions for Individuals Residing Outside Ohio**

Individuals residing outside Ohio must contact the Board by email at [med.license@med.state.oh.us](mailto:med.license@med.state.oh.us) to request the appropriate forms. The Board will mail the forms needed for your fingerprints to be processed at your local law enforcement agency.



# State Medical Board of Ohio

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## APPLICATION FOR CERTIFICATE TO PRACTICE A LIMITED BRANCH

### MASSAGE THERAPY

PLEASE TYPE OR PRINT CLEARLY

I am applying to take the:  
(*check only one*)

- June 2009 exam  
 December 2009 exam

**NOTE: Application fee is \$250.00. Fees submitted are neither refundable nor transferable.**

### IDENTIFICATION

Your social security number is required to facilitate reporting to the federal Healthcare Integrity & Protection Data Bank (42 U.S.C. §1320a-7e(b), 5 U.S.C. §552a, and 45 C.F.R. pt. 61) and for accurate identification under the federal and state child support enforcement law (42 U.S.C. §666 and §3123.50, O.R.C.). It may also be used for reporting to the National Practitioner Data Bank (42 U.S.C. §11101 and 45 C.F.R. pt. 60) and for other investigative/enforcement purposes in compliance with Chapters 4730., 4731., 4760. or 4762., O.R.C. or as otherwise required by state or federal law.

<b>U.S. Social Security Number</b>		_____			
<b>Full Name</b> (Use no initials)	Last	First	Middle	Suffix (Jr., II)	
<b>Maiden Name or other names used</b> (If none, enter "NONE")	Last	First	Middle	<b>Dates Used</b>	
				From: ___/___/___	To: ___/___/___
<b>Current Home Address</b> <b>IMPORTANT</b> Notify the Board office immediately, in writing, of any change in address	Number & Street			Apt.	
	City	State	Zip Code	Country	
<b>Mailing Address</b> If different from above	Number & Street			Apt.	
	City	State	Zip Code	Country	
<b>Telephone Number</b>	Business: (____) _____		Home: (____) _____		
<b>Birth Date</b>	month/day/year / /	<b>Birth Place</b>	City	State	Country
<b>Physical Description</b>	Height	Weight	Hair Color	Eye Color	Identifying marks
<b>Gender</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female		For statistics only (optional)		
<b>Ohio Preliminary Education Number</b>			<b>Date Issued</b>		

**PROFESSIONAL EDUCATION**

<b>Massage Therapy School of Graduation</b>	School Name _____			
	City _____	State _____	Country _____	
<b>Dates Attended</b>	From:      mo/yr /    /	To:         mo/yr /    /	<b>Date Diploma Received or to be received</b>	mo/day/yr /    /

<b>Other Massage Therapy Schools Attended (If none, enter "NONE")</b>	School Name _____			
	City _____	State _____	Country _____	
<b>Dates Attended</b>	From:      mo/yr /    /	To:         mo/yr /    /	<b>Reason degree not received at this school</b>	

**LICENSES IN THE UNITED STATES OR CANADA**

List ALL states/provinces, whether the license is current or not, in which you are or have been licensed to practice massage therapy or other health profession(s). Indicate the license number, date of issuance and the type of license (e.g., massage therapy, cosmetic therapy, etc.). If additional space is needed, please attach an extra sheet. (If none, enter "NONE")

State	Issue Date mo/yr	License No.	Type of License	License Current
	/			<input type="checkbox"/> Yes <input type="checkbox"/> No Expiration Date: _____ <span style="margin-left: 100px;">mo/yr</span>
	/			<input type="checkbox"/> Yes <input type="checkbox"/> No Expiration Date: _____ <span style="margin-left: 100px;">mo/yr</span>
	/			<input type="checkbox"/> Yes <input type="checkbox"/> No Expiration Date: _____ <span style="margin-left: 100px;">mo/yr</span>
	/			<input type="checkbox"/> Yes <input type="checkbox"/> No Expiration Date: _____ <span style="margin-left: 100px;">mo/yr</span>
	/			<input type="checkbox"/> Yes <input type="checkbox"/> No Expiration Date: _____ <span style="margin-left: 100px;">mo/yr</span>

Applicant Name: \_\_\_\_\_ Date: \_\_\_\_\_

## Massage Therapy Resume of Activities

List **ALL** activities in chronological order for the last five years, using **MONTH** and **YEAR**. If you have not been out of high school for five years, only list activities from high school graduation to the present time. **Be sure to use business addresses for all working time.** For any non-working time, you **MUST** state on the resume exactly what your activities were, such as “vacation” or “looking for work”, as well as your permanent home address. **DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS FORM.** If additional space is needed, please attach separate sheets.

From Month/Year _____ / _____ _____ To Month/Year _____ / _____	Employer or Non-working Activity  Complete Street Address _____ _____ Number & Street _____ _____ City                                      State/Country                                      Zip Code	Position
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From Month/Year _____ / _____ _____ To Month/Year _____ / _____	Employer or Non-working Activity  Complete Street Address _____ _____ Number & Street _____ _____ City                                      State/Country                                      Zip Code	Position
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From Month/Year _____ / _____ _____ To Month/Year _____ / _____	Employer or Non-working Activity  Complete Street Address _____ _____ Number & Street _____ _____ City                                      State/Country                                      Zip Code	Position
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From Month/Year _____ / _____ _____ To Month/Year _____ / _____	Employer or Non-working Activity  Complete Street Address _____ _____ Number & Street _____ _____ City                                      State/Country                                      Zip Code	Position
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From Month/Year _____ / _____ _____ To Month/Year _____ / _____	Employer or Non-working Activity  Complete Street Address _____ _____ Number & Street _____ _____ City                                      State/Country                                      Zip Code	Position
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Applicant Name: \_\_\_\_\_ Date: \_\_\_\_\_

**State Medical Board of Ohio**  
**Massage Therapy Resume of Activities**  
**Page 2**

From Month/Year _____ / _____  To Month/Year _____ / _____	Employer or Non-working Activity  Complete Street Address _____  Number & Street _____  City _____ State/Country _____ Zip Code _____	Position    
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From Month/Year _____ / _____  To Month/Year _____ / _____	Employer or Non-working Activity  Complete Street Address _____  Number & Street _____  City _____ State/Country _____ Zip Code _____	Position    
--	---	--------------------------

From Month/Year _____ / _____  To Month/Year _____ / _____	Employer or Non-working Activity  Complete Street Address _____  Number & Street _____  City _____ State/Country _____ Zip Code _____	Position    
--	---	--------------------------

From Month/Year _____ / _____  To Month/Year _____ / _____	Employer or Non-working Activity  Complete Street Address _____  Number & Street _____  City _____ State/Country _____ Zip Code _____	Position    
--	---	--------------------------

From Month/Year _____ / _____  To Month/Year _____ / _____	Employer or Non-working Activity  Complete Street Address _____  Number & Street _____  City _____ State/Country _____ Zip Code _____	Position    
--	---	--------------------------

From Month/Year _____ / _____  To Month/Year _____ / _____	Employer or Non-working Activity  Complete Street Address _____  Number & Street _____  City _____ State/Country _____ Zip Code _____	Position    
--	---	--------------------------

Applicant Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Massage Therapy  
Additional Information Questions**

If you answer "YES" to any of the following questions, **you** are **required** to furnish complete details, including date, place, reason and disposition of the matter. **All affirmative answers must be thoroughly explained on a separate sheet of paper.** Please note that some questions require very specific and detailed information. Make sure all responses are complete.

(Please place a  in the yes or no box)

		YES	NO
1.	Have you ever resigned from, withdrawn from, or terminated, or have you ever been requested to resign from, withdraw from, or otherwise been terminated from, a position with a partnership, professional association, corporation, or other organization, either private or public, involved in the practice of massage therapy?	<input type="checkbox"/>	<input type="checkbox"/>
2.	Have you ever resigned from, withdrawn from, or have you ever been warned by, censured by, disciplined by, been put on probation by, been requested to withdraw from, dismissed from, been refused renewal of a contract by, or expelled from, a massage therapy school, apprenticeship, or course of instruction related to massage therapy?	<input type="checkbox"/>	<input type="checkbox"/>
3.	Has any board, bureau, department, agency or other body, including those in Ohio, in any way limited, restricted, suspended, or revoked any professional license, certificate or registration granted to you; placed you on probation; or imposed a fine, censure or reprimand against you?	<input type="checkbox"/>	<input type="checkbox"/>
4.	Have you ever voluntarily surrendered, resigned, or otherwise forfeited any professional license, certificate or registration issued to you by any board, bureau, department, agency, or other body; or have you ever withdrawn any application for licensure, relicensure, or examination, in any state (including Ohio), territory, province, or country?	<input type="checkbox"/>	<input type="checkbox"/>
5.	Have you ever, for any reason, been denied licensure or relicensure, application for licensure or relicensure, or the privilege of taking an examination, in any state (including Ohio), territory, province, or country?	<input type="checkbox"/>	<input type="checkbox"/>
6.	Have you ever been requested to appear before any board, bureau, department, agency, or other body, including those in Ohio, concerning allegations against you?	<input type="checkbox"/>	<input type="checkbox"/>
7.	Have you ever entered into an agreement of any kind, whether oral or written, with respect to a professional license, in lieu of or in order to avoid formal disciplinary action, with any board, bureau, department, agency, or other body, including those in Ohio?	<input type="checkbox"/>	<input type="checkbox"/>
8.	Have you ever been notified of any investigation concerning you by any board, bureau, department, agency, or other body, including those in Ohio, with respect to a professional license?	<input type="checkbox"/>	<input type="checkbox"/>

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

Date: \_\_\_\_\_

State Medical Board of Ohio  
 Massage Therapy Additional Information Questions  
 Page 2

		YES	NO
9.	Have you ever been notified of any charges, allegations, or complaints filed against you with, any board, bureau, department, agency, or other body, including those in Ohio, with respect to a professional license?	<input type="checkbox"/>	<input type="checkbox"/>
10.	Have you ever been denied, or have you ever surrendered, a state or federal controlled substance or drug registration; had it revoked, terminated, or restricted in any way; or been warned, reprimanded, or fined by, or been requested to appear before, the responsible agency?	<input type="checkbox"/>	<input type="checkbox"/>
11.	Have you ever been convicted or found guilty of a violation of any law, regardless of the legal jurisdiction in which the act was committed, other than a minor traffic violation? If yes, submit copies of all relevant documentation, such as police reports, <b>certified</b> court records and any institutional correspondence and orders. <b>Photocopies will not be accepted.</b>	<input type="checkbox"/>	<input type="checkbox"/>
12.	Have you ever forfeited collateral, bail, or bond for breach or violation of any law, police regulation, or ordinance other than for a minor traffic violation; been summoned into court as a defendant or had any lawsuit filed against you (other than a malpractice suit)? If yes, submit copies of all relevant documentation, such as police reports, <b>certified</b> court records and any institutional correspondence and orders. <b>Photocopies will not be accepted.</b>	<input type="checkbox"/>	<input type="checkbox"/>
13.	Have you been a defendant in a legal action involving professional liability (malpractice), or had a professional liability claim paid on your behalf, or paid such a claim yourself? If yes, include the case name, case number, court and address, date filed, and a summary of the underlying events. Indicate current status, including amount of settlement or judgment, if any. In addition, ask your malpractice insurance carrier(s) to provide a complete claims history report for the last 10 years to the State Medical Board of Ohio. If your current carrier has provided coverage for less than 10 years, ask your previous carrier to submit a claims history report to the Board.	<input type="checkbox"/>	<input type="checkbox"/>
14.	Have you ever been denied professional liability insurance or coverage, or had such insurance or coverage canceled, limited, or restricted in any way?	<input type="checkbox"/>	<input type="checkbox"/>
15.	Have you ever been denied or relinquished participation in any third party reimbursement program, whether governmental or private, including Worker's Compensation; or had such participation limited, restricted, suspended, or revoked; or been warned, reprimanded, requested to appear before, or fined by the responsible body?	<input type="checkbox"/>	<input type="checkbox"/>
16.	Have you ever, while not holding a valid license from the State Medical Board of Ohio or from any other board, bureau, department, agency or body granting the right to practice massage therapy, practiced, advertised, announced yourself as practicing or conducted an office for the practice of massage therapy in Ohio?	<input type="checkbox"/>	<input type="checkbox"/>
17.	Have you ever practiced, advertised, announced yourself as practicing or conducted an office for the practice of massage therapy without holding a required valid license, permit, certificate, or registration from a municipality or township?	<input type="checkbox"/>	<input type="checkbox"/>

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

Date: \_\_\_\_\_

		YES	NO
18.	Have you ever been diagnosed as having, or have you been treated for, pedophilia, exhibitionism, or voyeurism? If yes, please explain.	<input type="checkbox"/>	<input type="checkbox"/>
19.	a) Within the last ten years, have you been diagnosed with or have you been treated for, bipolar disorder, schizophrenia, paranoia, or any other psychotic disorder?	<input type="checkbox"/>	<input type="checkbox"/>
	b) Have you, since attaining the age of eighteen or within the last ten years, whichever period is shorter, been admitted to a hospital or other facility for the treatment of bipolar disorder, schizophrenia, paranoia, or any other psychotic disorder?	<input type="checkbox"/>	<input type="checkbox"/>
	If you answered "YES" to any part of this question, please provide details on a separate sheet, including date(s) of diagnosis or treatment, and a description of your present condition. Include the name, current mailing address, and telephone number of each person who treated you, as well as each facility where you received treatment, and the reason for treatment. Have each treating physician submit a letter detailing the dates of treatment, diagnosis and prognosis.		

For purposes of questions 20 and 21 the following phrases or words have the following meaning:

*"Ability to practice massage therapy"* is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical assessments and exercise reasoned judgments and to learn and keep abreast of developments in the field of massage therapy; and
2. The ability to communicate those judgments and information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform massage therapy with or without the use of aids or devices, such as corrective lenses or hearing aids.

*"Medical condition"* includes physiological, mental, or psychological conditions or disorders, such as but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

		YES	NO
20.	Do you have, or have you been diagnosed as having, a medical condition which in any way impairs or limits your ability to practice massage therapy with reasonable skill and safety? If yes, please explain.	<input type="checkbox"/>	<input type="checkbox"/>
	a) Are the limitations or impairment caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medication) or participate in a monitoring program? If yes, please explain.	<input type="checkbox"/>	<input type="checkbox"/>
	If you receive such ongoing treatment or participate in such monitoring program the board will make an individualized assessment of the nature, severity, and duration of the risk associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure. Have each treating physician submit a letter detailing the dates of treatment, diagnosis and prognosis.		
	b) Are the limitation or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? If yes, please explain.	<input type="checkbox"/>	<input type="checkbox"/>

Applicant Name: \_\_\_\_\_ Date: \_\_\_\_\_

“*Chemical substances*” is to be construed to include alcohol, drugs, or medications including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescribers direction, as well as those used illegally.

		YES	NO
21.	Do you use chemical substance(s) which in any way impair or limit your ability to practice massage therapy with reasonable skill and safety? If yes, please explain.	<input type="checkbox"/>	<input type="checkbox"/>
	a) Are the limitations or impairment caused by your use of chemical substances reduced or ameliorated because you receive ongoing treatment (with or without medication) or participate in a monitoring program? If yes, please explain.  If you receive such ongoing treatment or participate in such monitoring program the board will make an individualized assessment of the nature, severity, and duration of the risk associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure. Have each treating physician submit a letter detailing the dates of treatment, diagnosis and prognosis.	<input type="checkbox"/>	<input type="checkbox"/>
	b) Are the limitation or impairments caused by your use of chemical substances reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? if yes, please explain.	<input type="checkbox"/>	<input type="checkbox"/>

For purposes of question 22 the following phrases or words have the following meaning:

“*Currently*” does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather it means recently enough so that the use of drugs may have an ongoing impact on one’s functioning as a licensee, or within the past two years.

“*Illegal use of controlled substances*” means the use of controlled substances obtained illegally (e.g. heroin or cocaine) as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the direction of a licensed healthcare practitioner.

		YES	NO
22.	Are you currently engaged in the illegal use of controlled substances?	<input type="checkbox"/>	<input type="checkbox"/>
	a) If “YES,” are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not using illegal controlled substances. If yes, please explain.	<input type="checkbox"/>	<input type="checkbox"/>

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

Date: \_\_\_\_\_



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## MASSAGE THERAPY FORM 1 - CERTIFICATE OF RECOMMENDATION

This form is to be completed by a resident of the state in which you are residing. They must be sufficiently acquainted with the applicant for at least **SIX** months. Relatives may not serve as recommenders. This form must be notarized by the recommender.

**DO NOT COMPLETE UNLESS A COLOR PHOTO OF APPLICANT IS ATTACHED**  
**BLACK & WHITE PHOTOS WILL NOT BE ACCEPTED**

I, \_\_\_\_\_, affirm that \_\_\_\_\_,  
(recommender, print name legibly) (applicant, print name legibly)

has been known to me personally for \_\_\_\_\_ years and that he/she is of good moral character.

Further, the photograph affixed hereto is a genuine likeness of the applicant.

I hereby recommend him/her for a license to practice Massage Therapy in the State of Ohio.

Address of Recommender	Number & Street			Telephone Number (include area code)
	City	State	Zip Code	
Signature of Recommender (name stamps not accepted)				

**PHOTOGRAPH**

**Applicant:** Staple a recent passport-type size **COLOR** photo of yourself here; must have been taken within the last six months

**(black & white photos will not be accepted)**

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
Notary Public Signature

\_\_\_\_\_  
Date Commission Expires

\_\_\_\_\_  
Signature of Applicant

Date Photo Taken: \_\_\_\_\_ / \_\_\_\_\_  
month/year

**NOTARY SEAL**



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## MASSAGE THERAPY FORM 1 - CERTIFICATE OF RECOMMENDATION

This form is to be completed by a resident of the state in which you are residing. They must be sufficiently acquainted with the applicant for at least **SIX** months. Relatives may not serve as recommenders. This form must be notarized by the recommender.

**DO NOT COMPLETE UNLESS A COLOR PHOTO OF APPLICANT IS ATTACHED**  
**BLACK & WHITE PHOTOS WILL NOT BE ACCEPTED**

I, \_\_\_\_\_, affirm that \_\_\_\_\_,  
(recommender, print name legibly) (applicant, print name legibly)

has been known to me personally for \_\_\_\_\_ years and that he/she is of good moral character.

Further, the photograph affixed hereto is a genuine likeness of the applicant.

I hereby recommend him/her for a license to practice Massage Therapy in the State of Ohio.

Address of Recommender	Number & Street			Telephone Number (include area code)
	City	State	Zip Code	
Signature of Recommender (name stamps not accepted)				

**PHOTOGRAPH**

**Applicant:** Staple a recent passport-type size **COLOR** photo of yourself here; must have been taken within the last six months

**(black & white photos will not be accepted)**

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
Notary Public Signature

\_\_\_\_\_  
Date Commission Expires

\_\_\_\_\_  
Signature of Applicant

Date Photo Taken: \_\_\_\_\_ / \_\_\_\_\_  
month/year

**NOTARY SEAL**



# State Medical Board of Ohio

30 E. Broad St., 3rd Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: [www.http://ohio.gov/](http://ohio.gov/)

## MASSAGE THERAPY FORM 2 - CERTIFICATE OF EDUCATION

**Instructions to school:** Please complete the form and return to the State Medical Board of Ohio at the above address. **Please note that form is not to be completed prior to graduation.** Also, submit a copy of diploma.

This certifies that \_\_\_\_\_ received a diploma from  
name of applicant, print legibly

\_\_\_\_\_ on \_\_\_\_\_  
Name of massage therapy school date of graduation (mo/day/yr)

I further certify that he/she has completed instruction in Massage and that his/her instruction included: practical and theoretical instruction in Massage and the following as related to Massage: Anatomy, Physiology, Pathology, Ethics, Clinical Program, and Hygiene and such other subjects as the Board deems necessary and appropriate to Massage. The course of instruction was for a period of not less than nine months and minimum of 750 clock hours.

Dates of attendance \_\_\_\_\_ to \_\_\_\_\_  
mo/day/yr mo/day/yr

### SCHOOL SEAL

(If school has no seal, indicate and have form notarized)

\_\_\_\_\_  
Signature of President, Dean or Secretary  
(NAME STAMPS ARE NOT ACCEPTABLE)

\_\_\_\_\_  
Name (please print)

\_\_\_\_\_  
Position

**MASSAGE THERAPY  
AFFIDAVIT AND RELEASE OF APPLICANT**

The affidavit and release **MUST** be completed by **ALL** applicants. The form must be notarized. Failure of any applicant to submit the affidavit completed and notarized with the application will result in your application being considered as incomplete.

ss      STATE OF: \_\_\_\_\_  
          COUNTY OF: \_\_\_\_\_

I, \_\_\_\_\_, hereby certify under oath that I am the person named in this application for a license to practice Massage Therapy in the State of Ohio; that all statements I have made or shall make with respect thereto are true, that I am the original and lawful possessor and person named in the various forms and credentials furnished or to be furnished to this Board with respect to my application; and that all documents, forms, or copies thereof furnished or to be furnished with respect to my application are strictly true in every respect.

I acknowledge that I have read the general information and instructions for all applicants and that I have answered all questions in compliance with these instructions and understand that the fee I submitted is neither refundable nor transferable.

I further state that by filing this application for a license to practice Massage Therapy in the State of Ohio, I hereby authorize and consent to have an investigation made as to my moral character, professional reputation and fitness for the practice of Massage Therapy. I agree to give any further information which may be required in reference to my past record. I understand that I will not receive a copy of any reports or know their contents and I further understand that the contents of any investigative report will be privileged.

I further understand that my application for a license to practice Massage Therapy in the State of Ohio is an ongoing process. I will immediately notify the State Medical Board of Ohio in writing of any changes to the answers to any of the questions contained in the ADDITIONAL INFORMATION section of the application if such a change in an answer is warranted at any time prior to licensure being granted to me by the State Medical Board of Ohio. I further understand that failure to complete this application as requested by the Board within six months can be considered abandonment of any request for licensure and that any fee I submitted is neither refundable nor transferable.

I authorize and request every person, hospital, clinic, governmental agency (local, state, federal or foreign), court, association, institution, or law enforcement agency having control of any documents, records and other information pertaining to me to furnish to the State Medical Board of Ohio any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the State Medical Board of Ohio or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application, subsequent licensure or practice thereunder.

I hereby release, discharge, and exonerate the State Medical Board of Ohio, its agents or representatives and any person, hospital, clinic, governmental agency (local, state, federal or foreign), court, association, institution, or law enforcement agency furnishing information, of any and all liability of every nature and kind arising out of investigation made by the State Medical Board of Ohio. I authorize the State Medical Board of Ohio to release information, material, documents, orders or the like relating to me or to this application to any other governmental agency (local, state, federal or foreign); or to any hospital, nursing home, clinic, health maintenance organization or similar institution; or to any professional association.

I further understand that issuance of a certificate to practice a limited branch of medicine or surgery in Ohio will be considered on the truth of the statements and documents contained herein or to be furnished, which if false, can subject me to denial of said certificate.

\_\_\_\_\_  
Signature of Applicant

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_ 20 \_\_\_\_\_

\_\_\_\_\_  
Signature of Notary Public

**(NOTARY SEAL)**

\_\_\_\_\_  
Date Commission Expires