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 Certificate to Practice. Please read the instructions thoroughly before completing the application. You must complete the entire application and submit all required documentation.

Please be aware that although the Federation of State Massage Therapy Boards (fsmtb.org) does not restrict when an applicant may take the exam, the State Medical Board of Ohio requires you to pass the Massage and Bodywork Licensing Exam (MBLEx) prior to submitting an application for Ohio licensure. You must submit each Score Report sheet you receive the day of each attempt you make of the MBLEx. Any application received without a Score Report sheet proving you have passed the exam will not be accepted.

Please note that once submitted an application cannot be withdrawn without the approval of the State Medical Board of Ohio.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

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

Applications submitted without the fee will not be processed until the fee is received. The application processing time is ordinarily, but not guaranteed, 60 days after receipt of an application and fee to the Board. Failure to submit all required information and documentation or other unusual circumstances will result in processing delays.

Attachments:

Revised 1/24/13

MASSAGE THERAPY APPLICATION CHECKLIST

This checklist is for your use and to help you determine the items you will be required to submit with your application for the massage therapy certificate to practice. Once your application is received an "Online Application Status" letter will be mailed to you. This letter will allow you to check the status of your application online.

ALL APPLICANTS MUST:

- ❑ Complete the **APPLICATION FOR CERTIFICATE TO PRACTICE – MASSAGE THERAPY** in its entirety including:
  - ❑ **RESUME OF ACTIVITIES** - You must list ALL activities for the last five years to the present time. Even if not working, indicate your activities and home address for that time. If you have been out of high school for less than five years, only list activities starting with high school graduation to the present time. The end date of the last activity and/or the date you completed the application must not be more than 30 days prior to the date your application was mailed to the Board. Be sure to use business addresses for all working time.
  - ❑ **ADDITIONAL INFORMATION QUESTIONS (1 through 21)** - Please be advised that you must thoroughly explain any affirmative answers. You must give your account of the event(s). All affirmative answers are subject to an additional review and are completed in the order in which they are received. Once the additional review is complete you will be notified. Updates of the additional review are **not** provided unless additional information has been requested, at which time you will be contacted. In addition, if you answer yes to Question 14, you must complete and submit the Criminal Offense Information form in its entirety. You must also submit certified copies of all relevant documentation, such as a copy of the police report/arrest record, a copy of the charge/ticket and a copy of the final court disposition. Please note that some questions specifically ask for **certified** documents.
  - ❑ **AFFIDAVIT AND RELEASE OF APPLICANT** - This form must be notarized. The date the form was notarized must be less than six months from the date your application was mailed to the Board.
  - ❑ Enclose the application fee of **$150.00**. Make check or money order payable to **Treasurer, State of Ohio**. *Fees are neither refundable nor transferable*. **DO NOT SEND CASH!**
  - ❑ **BCI AND FBI BACKGROUND CHECKS** - Request a criminal records check from the Ohio BCI and FBI (refer to the Criminal Records Check instruction sheet for additional information).
  - ❑ **FORM 1 – CERTIFICATE OF RECOMMENDATION** - Attach (do **not** staple or paperclip) a recent (taken within the last six months from the date the application was mailed to the Board) passport-type **COLOR** photo to each of the two Certificates of Recommendation, sign your name and indicate the date your photo was taken beneath your photograph. Then, forward to two people for completion of these recommendations. It is the responsibility of each recommender to complete *and* have the recommendation form notarized in the state in which he/she lives. The people you choose to complete each form must have known you at least six months. Relatives and/or persons with the same last name as you may not serve as recommenders. Black and white photos will not be accepted.
  - ❑ **FORM 2 - CERTIFICATE OF EDUCATION** - This form must be completed by the President, Dean or Secretary of the school of graduation or their designee. This form is **not** to be completed ***prior*** to graduation.

- ❑ **FORM 3- VERIFICATION OF LICENSE** - The State Medical Board of Ohio requires that this form be completed by each State or Canadian Province in which you hold or have held licenses, registrations or certifications to practice massage therapy or other health professions, whether now current or not. After completing the top portion of the form you must forward the entire form <u>directly to the entity which issued</u> your licenses, registrations and/or certifications for completion. Because some entities charge a fee to verify your license, registrations or certifications, it would be beneficial to contact the entity to inquire about a fee before submitting the request for verification. (Examples include but are not limited to: MT, LMT, STNA, RN, LPN, and any other professional license) If you never been issued a professional license write “N/A” for “Not Applicable”

- ❑ Enclose a photocopy of your massage therapy diploma.

- ❑ Submit, with your application, your MBLEx Score Report sheet from the FSMTB for verification purposes. If you have taken the exam more than once, you must submit a Score Report sheet for each attempt. Failure to submit the Score Report Sheet(s), including the sheet with your passing score, will result in your application not being accepted. Fees will not be refunded nor transferred to any future application submitted if your present application is not accepted.

- ❑ Please make sure that you legibly print your name and date the bottom of each page of the application in the space provided.

Revised 1/24/13

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 TO PRACTICE – 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 **$150.00** made payable to **Treasurer, State of Ohio**, with your completed application. **FEES SUBMITTED ARE NEITHER REFUNDABLE NOR TRANSFERABLE. DO NOT SEND CASH.**

3. Request a criminal records check from the Ohio BCI and FBI (refer to the Criminal Records Check instruction sheet for additional information).

4. Submit, with your application, your Massage and Bodywork Licensing Exam (MBLEx) Score Report sheet from the Federation of State Massage Therapy Boards (FSMTB) for verification purposes. If you have taken the exam more than once, you must submit a Score Report sheet for each attempt. Failure to submit the Score Report Sheet(s), including the sheet with your passing score, will result in your application not being accepted. Fees will not be refunded nor transferred to any future application submitted if your present application is not accepted.

5. Attach (do **not** staple or paperclip) a recent (taken within the last six months from the date you mailed your application to the Board) passport-type **COLOR** photo to each of the two Certificates of Recommendation, sign your name and indicate the date your photo was taken beneath your photograph. Then, forward to two people for completion of these recommendations. It is the responsibility of each recommender to complete *and* have the recommendation form notarized in the state in which he/she lives. The people you choose to complete each form must have known you at least six months. Relatives and/or persons with the same last name as you may not serve as recommenders. Black and white photos will not be accepted.

6. Enclose a photocopy of your massage therapy diploma.

7. 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 or their designee. This form is **not** to be completed ***prior*** to graduation.

8. The State Medical Board of Ohio requires that the Form 3 – Verification of License be completed by each State or Canadian Province in which you hold or have held licenses, registrations or certifications to practice massage therapy or other health professions, whether now current or not. After completing the top portion of the form you must forward the entire form directly to the entity which issued your licenses, registrations and/or certifications for completion. Because some entities charge a fee to verify your license, registrations or certifications, it would be beneficial to contact the entity to inquire about a fee before submitting the request for verification. (Examples include but are not limited to: MT, LMT, STNA, RN, LPN, and any other professional license) If you never been issued a professional license write "N/A" for "Not Applicable"

9. **Definitions:** The following phrases or words in the Additional Information Questions have the following meaning:

    a. "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.

    b. "Chemical substances" includes alcohol, drugs or medications including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

c. "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.

d. "Illegal use of controlled substances" means the use of controlled substances obtained illegally (e.g. marijuana, 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.

10. 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

Revised 1/4/12

Application Process

The State Medical Board processes hundreds of applications for certificates to practice a limited branch of medicine. 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.

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.

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 3 to 4 weeks after licensure. Hospitals, insurance companies, etc., must obtain verification of your Ohio license directly from the Board's website in the "Licensee Profile and Status" section. The Ohio Medical Board website address is https://license.ohio.gov/lookup. 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

The Ohio Medical Board operates a "staggered renewal" system based upon the first letter of your last name at the time of licensure. Each licensee will remain in his/her originally assigned group for all subsequent renewals. There are eight renewal groups; each group has its own renewal and expiration dates. Each renewal period after the initial renewal period is two years long. Renewal notices are mailed approximately 6 months before a license expires.

CRIMINAL RECORDS CHECK REQUIRED FOR INITIAL LICENSURE
MASSAGE 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 (BCI) 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 BCI. The Board will typically receive the results of criminal records checks submitted via "WebCheck" within 7 to 10 business days. In addition to the BCI 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 BCI 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/Business/Services-for-Business/WebCheck/Webcheck-Community-Listing

When locating an electronic fingerprinting site on this web page, please note that you MUST use the services of a vendor that has (BCI 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 BCI 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 BCI and FBI.

Steps for "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 BCI and FBI be sent directly to:

State Medical Board of Ohio
30 E. Broad St., 3rd 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 tamara.spencer@med.state.oh.us to request the appropriate forms. Ohio forms must be used. The Board will mail the forms needed for your fingerprints to be processed at your local law enforcement agency.

Revised 2/10/11

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APPLICATION FOR CERTIFICATE TO PRACTICE A LIMITED BRANCH OF MEDICINE

MASSAGE THERAPY

PLEASE TYPE OR PRINT CLEARLY IN BLACK INK ONLY

NOTE: Application fee is $150.00. 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 Chapter 4731. O.R.C. or as otherwise required by state or federal law.

U.S. Social Security Number	____ - ____ -			
Full Name (Use NO initials)	Last	First	Middle	Suffix (Jr., II)
Maiden Name or other names used (If none, enter "NONE")	Last	First	Middle	**Dates Used** From: mo/yr ___/___ To: mo/yr ___/___
	Last	First	Middle	From: mo/yr ___/___ To: mo/yr ___/___
Current Home Address IMPORTANT Notify the Board office immediately, in writing, of any change in address	Number & Street			Apt.
	City	State	Zip Code	County
Mailing Address If different from above	Number & Street			Apt.
	City	State	Zip Code	County
Email Address				
Telephone Number	Business: area code & number (_____) ________		Home: area code & number (_____) ________	
Birth Date	month/day/year / /	**Birth Place** City	State	Country
High School	Name of School	City		Date of Graduation
High School Equivalent	Type	Date of Completion		
Gender	❑ Male	❑ Female	For statistics only (optional)	

PROFESSIONAL EDUCATION

Massage Therapy School of Graduation	School Name City State Country			
Dates Attended	mo/yr From: /	mo/yr To: /	**Date Program Completed**	mo/day/yr / /

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

WRITTEN EXAMINATION

List **ALL** of the Massage and Bodywork Licensing Exam (MBLEx) attempts you have taken (**month and year**). YOU MUST SUBMIT COPIES OF EACH SCORE REPORT SHEET.

Date Taken: ______/______ ☐ Pass ☐ Fail
Date Taken: ______/______ ☐ Pass ☐ Fail
Date Taken: ______/______ ☐ Pass ☐ Fail
Date Taken: ______/______ ☐ Pass ☐ Fail

LICENSES IN THE UNITED STATES OR CANADA
(PLEASE PROVIDE VERIFICATION FOR EACH LICENSE LISTED)

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
	/			☐ Yes ☐ No Expiration Date:________ mo/yr
	/			☐ Yes ☐ No Expiration Date:________ mo/yr
	/			☐ Yes ☐ No Expiration Date:________ mo/yr

Applicant Name (print clearly):________________________ Date:____________

State Medical Board of Ohio

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

MASSAGE THERAPY AND COSMETIC THERAPY

FORM 3 - VERIFICATION OF LICENSE

I am applying for a license to practice Massage Therapy or Cosmetic Therapy in the State of Ohio. The State Medical Board of Ohio requires that this form be completed by each State or Canadian Province in which I hold or have held licenses, whether now current or not. *Please complete the form and return it directly to the State Medical Board of Ohio at the above address.*

TO BE COMPLETED BY APPLICANT

Name:____
last first middle suffix (Jr., II)

License Number:____________________ Date of Birth:____________________
month/day/year

School of Graduation:____

I hereby authorize the licensing agency of the State of ______________________ to furnish the information below to the State Medical Board of Ohio.

______________________________ ____________
Signature of Applicant Date

TO BE COMPLETED BY STATE BOARD OR CANADIAN PROVINCE

State:____________________

Name of Licensee:____
last first middle suffix (Jr., II)

License Number: ______________ Issue Date: ______________ Expire(d):______________
month/day/year month/day/year

License Type: ❑ Massage Therapy ❑ Cosmetic Therapy ❑ other:______________
(please specify)

Is the applicant currently the subject of a pending investigation by a licensing or disciplinary authority in your state?
❑ Yes ❑ No ❑ Cannot answer under current state law ***If yes, please attach complete details.***

Have formal disciplinary proceedings been initiated against applicant's license by a disciplinary authority in your state? ❑ Yes ❑ No ❑ Cannot answer under current state law ***If yes, please attach complete details.***

Has the applicant ever been warned, censured or in any other manner disciplines or has applicant's license been revoked, suspended, or in any other manner limited by a licensing or disciplinary authority in your state?
❑ Yes ❑ No ❑ Cannot answer under current state law ***If yes, please attach complete details.***

____
Signature

AFFIX BOARD SEAL
(NOT VALID WITHOUT SEAL)

____
Title

____
Date

Massage Therapy
Resume of Activities

List **ALL** activities in chronological order for the last five years to the present time, using **MONTH** and **YEAR**. If you have been out of high school for less than five years, only list activities starting with 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. Time periods longer than 30 days must be documented. **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

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 (print clearly):____________________ Date:____________

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

Applicant Name (print clearly):______________________________ 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 yes 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. A "yes" answer or failure to answer any questions truthfully could result in a denial of licensure. For definitions of key terms, please see #9 on the Application Instructions page.

(Please place a ☑ in the yes or no box)

		YES	NO
1.	Have you ever withdrawn or been terminated from any massage therapy school, apprenticeship or course of instruction related to massage therapy?	❑	❑
2.	Have you ever resigned from a massage therapy school, apprenticeship or course of instruction related to massage therapy?	❑	❑
3.	Have you ever been disciplined by a massage therapy school, apprenticeship or course of instruction related to massage therapy?	❑	❑
4.	Have you ever been terminated from a position you held with any business, organization, association and/or institution, either private or public, involved in the practice of massage therapy?	❑	❑
5.	Have you ever resigned from a position you held with any business, organization, association and/or institution, either private or public, involved in the practice of massage therapy?	❑	❑
6.	Have you ever practiced, advertised, announced yourself as practicing or conducted an office for practicing massage therapy while not holding a valid license from the State Medical Board of Ohio or from any other licensing agency?	❑	❑
7.	Have you ever practiced, advertised, announced yourself as practicing or conducted an office for practicing massage therapy without holding a required valid license, permit, certificate or registration from a municipality or township?	❑	❑
8.	Has any licensing board or agency, including those in Ohio, ever denied you a certificate or license?	❑	❑
9.	Has any licensing board or agency, including those in Ohio, ever refused you a renewal or reinstatement of a certificate or license?	❑	❑
10.	With respect to a professional license, have you ever been notified of any charges, allegations or complaints filed against you with any licensing agency, including those in Ohio?	❑	❑
11.	To your knowledge, are you the subject of an investigation by any licensing board or agency, including those in Ohio, as of the date of this application?	❑	❑
12.	Has any licensing board or agency, including those in Ohio, revoked, suspended or restricted your license or placed you on probation?	❑	❑
13.	Has any licensing board or agency, including those in Ohio, reprimanded, fined, disciplined, requested or accepted surrender of your license?	❑	❑

Applicant Name (print clearly):______________________________ Date:______________

		YES	NO
14.	Have you ever been charged with, arrested for, convicted of, sentenced for, pled guilty or no contest to, or are there any charges pending against you for any felony, misdemeanor, or any offense other than a minor traffic violation? **(DUI, DWI, OVI, Reckless Operation and any other offenses involving the use of alcohol or drugs are <u>NOT</u> minor traffic violations. Expunged records must be included. Arrests must be reported even if the charges were dismissed.)** If the answer is yes, please complete and submit a Criminal Offense Information form for each incident. You must also provide certified copies of the police report/arrest record, the charges/ticket, the final court disposition and any other relevant documentation.	❑	❑
	For questions 15-19, if you are less than 23 years of age, please do <u>not</u> include information prior to age 18		
15.	Within the past five years, have you engaged in the excessive or illegal use of any chemical substance(s), or received any in-patient or out-patient or individual therapy/treatment or been hospitalized for ongoing alcohol or drug abuse, or been arrested for driving under the influence?	❑	❑
16.	Within the past five years, have you refused a chemical substance screening test or have you been the subject of any chemical substance screening test which resulted in an indication of the presence in your body of any controlled substance, any dangerous drug or alcohol level above .08% BAC?	❑	❑
17.	Do you currently have, or have you had within the past five years, a dependency on or have you abused any chemical substance(s) which impaired or might reasonably impair your ability to practice massage therapy safely and competently?	❑	❑
18.	Do you currently have or have you had within the last five years, any medical condition, including but not limited to, bipolar disorder, schizophrenia, paranoia or any other psychotic disorder, which impaired or might reasonably impair your ability to practice massage therapy safely and competently? If the answer is yes, please provide a letter from your treating physician regarding your ability to practice massage therapy safely and competently.	❑	❑
19.	Within the past five years, have you been admitted to or treated by any hospital or other in-patient or out-patient facility for any medical condition, including but not limited to, bipolar disorder, schizophrenia, paranoia or any other psychotic disorder, which impaired or might reasonably be considered to impair your ability to practice massage therapy safely and competently? If the answer is yes, please provide a letter from your treating physician regarding your ability to practice massage therapy safely and competently.	❑	❑
20.	Have you ever been diagnosed as having, or have you been treated for, pedophilia, exhibitionism, voyeurism or other sexual behavior disorder?	❑	❑
	If you have authority to prescribe, please answer questions 21 a - d. All other applicants proceed to the signature line.		
21.	a. Are you currently registered with the Drug Enforcement Agency (DEA)? If yes, provide DEA number: ____________________________________	❑	❑
	b. If you are not currently registered with the DEA, have you been registered in the past? If yes, provide DEA number(s): ____________________________________	❑	❑
	c. Have you ever been denied a DEA registration?	❑	❑
	d. Have you ever had a DEA registration restricted, limited, revoked or suspended?	❑	❑

Applicant Name (print clearly):____ Date:______________

APPLICATION – CERTIFICATE TO PRACTICE MASSAGE THERAPY
CRIMINAL OFFENSE INFORMATION

This form must be competed if you have responded yes to Additional Information Question #14. *Make additional copies of this form as needed.*

Name of Applicant (print clearly): ____

OFFENSE INFORMATION:

Date of Incident: ____

Location of Incident: ____
City State

Were you arrested: ☐ Yes ☐ No

- If the incident was alcohol-related, did you submit to a breath, blood, urine or other test to determine the amount of alcohol in your body: ☐ Yes ☐ No
- If yes, type of test and result: ____

What offense(s) were you charged with: ____

____

Were the charges amended: ☐ Yes ☐ No

- If yes, what were the final charges: ____

____

DISPOSITION: ☐ Pending ☐ Charges Dismissed ☐ Charges Dropped

☐ Plea: ________________ ☐ Other: ________________________
Specify Specify

You must provide a detailed written explanation, in your own words, of the event including a description of the event, what led up to the event and the disposition (outcome) of the event. This must be described in your own words. Do not reference attached documentation. If additional space is needed, attach a separate sheet. Submit copies of the police report/arrest record, a copy of the charges or ticket, a certified copy of the final court disposition and any other relevant documentation.

____

____

____

____

____

____

____

____ ________________
Applicant Signature Date

Revised 1/4/12

State Medical Board of Ohio

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

MASSAGE THERAPY
FORM 1 - CERTIFICATE OF RECOMMENDATION

This form is to be completed by a resident of the state in which you are residing who has known you for at least **SIX** months. Relatives may **not** serve as recommenders. This form must be notarized.

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

PHOTOGRAPH

Applicant: Affix 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

NOTARY SEAL

____
Signature of Applicant

Date Photo Taken:______/______
month/year

State Medical Board of Ohio

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

MASSAGE THERAPY
FORM 1 - CERTIFICATE OF RECOMMENDATION

This form is to be completed by a resident of the state in which you are residing who has known you for at least **SIX** months. Relatives may **not** serve as recommenders. This form must be notarized.

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** ______________________ **City** **State** **Zip Code**	Telephone Number (include area code)	
Signature of Recommender (name stamps not accepted)			

PHOTOGRAPH

Applicant: Affix 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

NOTARY SEAL

____
Signature of Applicant

Date Photo Taken:______/______
month/year

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 further authorize and consent to the State Medical Board of Ohio and its agents or representatives accessing and reviewing my confidential personal information to carry out their responsibilities for the State Medical Board of Ohio.** 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 confidential.

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

Revised 1/4/12

State Medical Board of Ohio

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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 the applicant's 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, Business and Law, and Hygiene and such other subjects as the State Medical Board of Ohio deems necessary and appropriate to Massage. The course of instruction was for a period of not less than ______ months and minimum of ______ clock hours.

Dates of attendance __________ to __________
mo/day/yr mo/day/yr

____
Signature of President, Dean or Secretary or their designee
(NAME STAMPS ARE NOT ACCEPTABLE)

SCHOOL SEAL

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

____
Name (please print)

____
Position

Revised 2/10/11