

Regular Mailing Address

State Board of Massage Therapy
P.O. Box 2649
Harrisburg, PA 17105-2649
Phone: 717-783-7155

Courier Delivery Address

State Board of Massage Therapy
2601 North Third Street
Harrisburg, PA 17110
email: RA-massagetherapy@state.pa.us

Application Instructions for:

MESSAGE THERAPIST TEMPORARY PRACTICE PERMIT

A temporary practice permit may only be issued within 6 months of completion of an approved massage therapy educational program.

A temporary practice permit will allow the permit holder to practice massage therapy for a **MAXIMUM** period of **SIX MONTHS** from the date the permit is issued. If the applicant fails the licensing examination, the temporary practice permit **IMMEDIATELY EXPIRES** and the holder of the permit must immediately **STOP PRACTICING MASSAGE THERAPY AND RETURN THE PERMIT TO THE BOARD**. You may not practice massage therapy unless you hold a temporary practice permit or current license.

The permit may **not** be renewed or extended. The temporary practice permit shall be promptly returned by the applicant to the Board when the applicant receives a license to practice massage therapy or when the permit expires.

Once you pass the examination, you must reapply using the examination application to apply for the permanent license. The temporary practice permit does not automatically become a permanent license. The educational documents will be the only item that will not need to be resubmitted when you apply for the permanent license.

CHECKLIST FOR APPLICANTS FOR A TEMPORARY PRACTICE PERMIT

- _____ Complete, sign and date the application.
- _____ Enclose a check or money order in the amount of \$65.00. The check or money order should be made payable to the Commonwealth of Pennsylvania. The fee is not refundable. If all materials in support of your application are not received within 6 months of the date of your signature on the application, your application will not be processed and you will have to submit another application form and fee if you still wish to obtain a temporary practice permit.
- _____ Attach a copy of a legal form of identification, such as a driver's license, a current passport, or a valid state identification card. The copy should be submitted on an 8 ½ x 11 sheet of paper.
- _____ Attach the Certification of Good Moral Character form, filled out and signed by two individuals, who are not related to you, who have known you for at least six months.

_____ An official Criminal History Record Check (CHRC) from the state agency for every state in which you have resided for the past 5 years. The report(s) must be dated within 6 months of the date of your application for temporary practice permit. This report can be sent to you and forwarded to the Board with your application. For Pennsylvania CHRC, this can be done online at <http://epatch.state.pa.us>. For states that do not provide CHRC for employment purposes, we will accept an FBI background check.

_____a. If you have a criminal record, attach certified court documents related to the conviction(s) and a personal statement explaining the conviction(s) and what you have done since the conviction(s) that demonstrates that you are rehabilitated.

_____ Attach a copy of the front & back of your current Adult Basic CPR certification, including the expiration date of your CPR certification. Your card must be signed and if applicable, a copy of the legend must be included. The copy should be submitted on an 8 ½ x 11 sheet of paper. **Online CPR is not acceptable.**

_____ Complete the top section of the "Verification of Massage Therapy Education" form (pages 4-5) and give the form to the Dean, Registrar or Chairperson of your Massage Therapy Program. The school must complete the bottom section and attach your transcripts. A qualifying program must be a minimum of 600 hours. **The school seal MUST be affixed where indicated and the ORIGINAL form returned by the school directly to the Board office in an official school envelope.** The form must be completed **AFTER** you have received your certificate or degree: program completion may **NOT** be anticipated. **Out-of-state schools must attach a copy of their school certification/accreditation with the form.**

NAME OR ADDRESS CHANGE:

If the name you are currently using on your application is different than the name you used on any of the other documents required to be submitted with your application, or if you change your name after you submit this application, send evidence of your name change within ten (10) days. For example, send a copy of marriage certificate or court order authorizing the name change.

If your address changes after you have submitted your application, notify the Board office in writing of your name, old address and new address. Mail this information to the Board office at the address shown above within ten (10) days.

OTHER INFORMATION:

Maintain a copy of all documents sent to the Board. Send your application materials to the Board at: State Board of Massage Therapy, PO Box 2649, Harrisburg, PA 17105-2649 OR (for courier delivery) 2601 North Third St, Harrisburg, PA 17110.

You may view the Massage Therapy Law and the regulations of the Board online at www.dos.state.pa.us/massagetherapy.

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Fax: (717) 787-7769

MESSAGE THERAPIST TEMPORARY PRACTICE PERMIT APPLICATION

MAKE \$65.00 FEE PAYABLE TO "COMMONWEALTH OF PENNSYLVANIA". NOT REFUNDABLE OR TRANSFERABLE. A PROCESSING FEE OF \$20.00 WILL BE CHARGED FOR ANY CHECK OR MONEY ORDER RETURNED UNPAID BY YOUR BANK, REGARDLESS OF THE REASON FOR NON-PAYMENT.

NAME _____
Last First Middle Maiden/Other name used

ADDRESS _____
Street

City State Zip Code

SOCIAL SECURITY # _____ **BIRTH DATE** _____

PHONE NUMBER _____ **EMAIL ADDRESS** _____

EDUCATION

As required by Section 5 (a) (2), have you earned a high school diploma or equivalent? Yes ____ No ____

Include in chronological order high school and all massage therapy schools attended.

INSTITUTION AND LOCATION (Include city and state)	DATES ATTENDED	DIPLOMA, DEGREE OR CERTIFICATE AWARDED, If any
H.S.	From To	
M.T.	From To	
	From To	
	From To	

ANSWER THE FOLLOWING: If you answer "YES" to question(s) 2-5, give details on a separate 8 ½ X 11 sheet of paper AND provide a certified copy of all related official documentation.	YES	NO
1. Have you previously taken the National Certification Examination for Therapeutic Massage (NCETM), the National Certification Examination for Therapeutic Massage and Bodywork (NCETMB) or the Massage and Bodywork Licensure Examination (MBLEx)? If YES , give the exam MONTH and YEAR and to which STATE the result was reported:		
2. Do you use or abuse alcohol, drugs, narcotics, chemicals or any other type of material that would impair your practice of massage therapy?		
3. Have you been convicted, found guilty or pleaded nolo contendere, or received probation without verdict or accelerated rehabilitative disposition (ARD) as to any felony or misdemeanor, or do you have any criminal charges pending and unresolved in any state or jurisdiction? You are not required to disclose any criminal matter that has been expunged by order of a court.		
4. Have you ever possessed a license or other authorization to practice massage therapy or other occupation where you provide services to the public? If YES , list license type and state of issue:_____		
5. Have you ever withdrawn an application for a license or other authorization to practice massage therapy or any other occupation, denied or refused, or agreed not to reapply for a license in another state, territory or country? If YES , provide an explanation.		
6. Have you ever had a license or other authority to practice an occupation disciplined- including imposition of a fine, reprimand, suspension or revocation? If YES , name the license, state of issue and attach a copy of the disciplinary action: _____		

VERIFICATION

I verify that the statements in this application are true and correct to the best of my knowledge, information and belief. I understand that false statements are made subject the penalties of 18 PA C.S. Section 4904 relating to unsworn falsification to authorities and may result in the suspension or revocation of my licensure or registration. **I verify that I have read and am familiar with the provisions of the Pennsylvania Massage Therapy Law and regulations of the State Board of Massage Therapy (www.dos.state.pa.us/massagetherapy).** I also verify that this form is in the original format as supplied by the Department of State and has not been altered or otherwise modified in any way. I am aware of the criminal penalties for tampering with public records or information pursuant to 18 PA C.S. Section 4911.

Printed Name of Applicant

Signature of Applicant

Date

Note that disclosing your social security number on this application is mandatory in order for the State Board of Massage Therapy to comply with the requirements of the Federal Social Security Act pertaining to child support enforcement, as implemented in the Commonwealth of Pennsylvania at 23 Pa. C.S. § 4304.1(a). In order to enforce domestic child support orders, the Commonwealth's licensing boards must provide to the Department of Public Welfare information prescribed by DPW about the licensee, including the social security number. Additionally, disclosing the number is mandatory in order for this board to comply with the reporting requirements of the Federal Healthcare Integrity and Protection Data Bank. Reports to the HIPDB must include the licensee's social security number.

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Certification of Good Moral Character

To be completed by two individuals who have known you for at least six months. At least one of the references must hold a state massage therapy license. Do not use individuals who are related to you. ORIGINAL SIGNATURES ARE REQUIRED.

Name of Applicant: _____

I hereby certify that I have known the above applicant for at least 6 months and that the applicant has good moral character. I recommend the applicant for a license to practice massage therapy in the Commonwealth of Pennsylvania.

I have been personally acquainted with the applicant for _____ year(s) _____ month(s).

SIGNATURE: _____ Date: _____

Print or type name as signed above: _____

State in which licensed: _____ License Number: _____
(if applicable)

Name of Applicant: _____

I hereby certify that I have known the above applicant for at least 6 months and that the applicant has good moral character. I recommend the applicant for a license to practice massage therapy in the Commonwealth of Pennsylvania.

I have been personally acquainted with the applicant for _____ year(s) _____ month(s).

SIGNATURE: _____ Date: _____

Print or type name as signed above: _____

State in which licensed: _____ License Number: _____
(if applicable)

Return Completed Form to Applicant

January 2013
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VERIFICATION OF MASSAGE THERAPY EDUCATION

Applicant for **Temporary Practice Permit**

Applicant: Complete (by typing/printing in blue/black ink) top section and send form to your Massage Therapy program to complete and attach your transcripts.

NAME _____

ADDRESS _____

SOCIAL SECURITY # _____ DATE OF BIRTH _____

This section to be completed by the Dean, Registrar, or Chairperson of the Massage Therapy program at the United States school which the applicant COMPLETED. DO NOT complete this form in anticipation of completion.

I hereby certify that:

1) _____ successfully completed a Massage
(Applicant's name)
Therapy education program at _____ on _____.
(School name) (Date)

2) The curriculum completed by Applicant equals or exceeds the curriculum requirements set forth in 49 Pa Code § 20.11. **Hours completed** _____

_____ **At least 175 contact hours of instruction in anatomy & physiology, kinesiology & pathology, including training in the human immunodeficiency virus & related risks.**

_____ **At least 250 contact hours in massage therapy & bodywork assessment, theory & practice including sanitation, safety, & hygiene.**

_____ **At least 25 contact hours in professional ethics, and business & law related to a massage therapy business.**

_____ **At least 150 contact hours in related courses appropriate to a massage therapy curriculum as set forth in Section 20.13 (related to required knowledge base), including cardiopulmonary resuscitation.**

Name of applicant _____

3) The school is :

- A Pennsylvania Private Licensed School
- Operated within a regionally accredited College or University

(Name of College or University)

- Approved by the MT Board or Department of Education of _____
(State)

(Name & Signature of Dean/Registrar/Chairperson of M.T.Program)

(Date)

Name of Program _____

SEAL

Name of Controlling Institution _____

Address _____

**OUT-OF-STATE SCHOOLS- PLEASE ATTACH A COPY OF THE SCHOOL
CERTIFICATION/ACCREDITATION FOR THE TIMEFRAME THAT THE
STUDENT ATTENDED THE PROGRAM.**

**SCHOOL SHALL RETURN AN ORIGINAL COMPLETED FORM DIRECTLY TO BOARD OFFICE IN AN
OFFICIAL ENVELOPE AND ATTACH STUDENT TRANSCRIPTS. (DO NOT send a copy of this form or
use envelope if provided by applicant) Make sure to complete the form in its entirety as to not
delay the processing of the application.**