



**GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH – HEALTH PROFESSIONAL LICENSING ADMINISTRATION**

**NEW LICENSE APPLICATION
BOARD OF MASSAGE THERAPY**

Please read instructions before completing this form. If you have any questions, call HPLA Customer Service at **1-877-374-1157**, Monday through Friday, 8AM to 5PM EST. **A charge of \$65.00 will be imposed for dishonored checks (Public Law 89-208)**

SECTION 1. REQUESTED LICENSE TYPE/FEES (includes non-refundable application fee – see instructions)			
<input type="checkbox"/> MT – Massage Therapist by Examination \$262.00 <input type="checkbox"/> MT – Massage Therapist by Endorsement \$262.00 <input type="checkbox"/> Duplicate Licenses (limit 5) _____ X \$34.00 = \$ _____.00 Total Enclosed \$ _____.00	Make check or money order payable to <u>DC Treasurer</u> MAIL TO: Department of Health Health Professional Licensing Administration Board of Massage Therapy 899 North Capitol Street, NE, First Floor Washington, DC 20002		
	HPLA ONLY		
	Check \$	Check #	Staff
	\$ _____.00		

SECTION 2. APPLICANT NAME/DEMOGRAPHIC INFORMATION																																							
Enter your name exactly as it should appear on the license. If your name has changed at any point since you first attended college or university, please complete Section 4 on page 2. You must also provide a copy of a legal name change document for EACH time that it has changed. Acceptable documents for individuals are marriage certificates, divorce decrees, or court orders.																																							
<table style="width:100%; border-collapse: collapse;"> <tr> <td style="border-bottom: 1px solid black; width: 60%;"></td> <td style="border-bottom: 1px solid black; width: 5%;"></td> <td style="border-bottom: 1px solid black; width: 35%;"></td> </tr> <tr> <td style="font-size: small;">FIRST NAME</td> <td style="font-size: small;">MI</td> <td style="font-size: small;">LAST NAME</td> </tr> </table>				FIRST NAME	MI	LAST NAME	<table style="width:100%; border-collapse: collapse;"> <tr> <td style="border-bottom: 1px solid black; width: 10%;"></td> <td style="border-bottom: 1px solid black; width: 10%;"></td> <td style="border-bottom: 1px solid black; width: 10%;"></td> <td style="border-bottom: 1px solid black; width: 10%;"></td> <td style="border-bottom: 1px solid black; width: 10%;"></td> <td style="border-bottom: 1px solid black; width: 10%;"></td> <td style="border-bottom: 1px solid black; width: 10%;"></td> <td style="border-bottom: 1px solid black; width: 10%;"></td> </tr> <tr> <td style="font-size: x-small;">M</td> <td style="font-size: x-small;">M</td> <td style="font-size: x-small;">D</td> <td style="font-size: x-small;">D</td> <td style="font-size: x-small;">Y</td> <td style="font-size: x-small;">Y</td> <td style="font-size: x-small;">Y</td> <td style="font-size: x-small;">Y</td> </tr> <tr> <td colspan="2" style="text-align: center;">[] – []</td> <td colspan="6" style="text-align: center;">[] – [] – [] – [] – [] – []</td> </tr> <tr> <td colspan="2" style="text-align: center;">SOCIAL SECURITY NUMBER</td> <td colspan="6" style="text-align: center;">DATE OF BIRTH</td> </tr> </table>									M	M	D	D	Y	Y	Y	Y	[] – []		[] – [] – [] – [] – [] – []						SOCIAL SECURITY NUMBER		DATE OF BIRTH					
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<table style="width:100%; border-collapse: collapse;"> <tr> <td style="border-bottom: 1px solid black; width: 80%;"></td> </tr> <tr> <td style="font-size: small; text-align: center;">PLACE OF BIRTH</td> </tr> </table> Provide City and State for US birthplace or Country for foreign place of birth.			PLACE OF BIRTH	<input type="checkbox"/> Male <input type="checkbox"/> Female GENDER Please check the correct box.																																			
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SECTION 3. SUPPORTING DOCUMENTS REQUIRED		
Please indicate the supporting documents you have included with this package or requested to be sent to the Board of Massage Therapy. Keep a photocopy of all supporting documents for your records.	HPLA ONLY	
A. Two recent and identical passport-type photos of the applicant's face (approx. 2"X2") with applicant's name printed on the back. The photos must be original photos and cannot be computer-generated copies or paper copies.	YES <input type="checkbox"/> NO <input type="checkbox"/>	<input type="checkbox"/>
B. Official transcript (with seal) from EACH approved or accredited institution. May be sent directly from the school, but it is preferred that it accompany the application in a sealed envelope.	YES <input type="checkbox"/> NO <input type="checkbox"/>	<input type="checkbox"/>
C. National Certification Examination for Therapeutic Massage and Bodywork, Inc. (NCETMB) score report or another examination's results certified by the National commission of Certifying Agencies (NCCA) and approved at the discretion of the Board.	YES <input type="checkbox"/> NO <input type="checkbox"/>	<input type="checkbox"/>
D. If you are or have ever been licensed in another state/jurisdiction: Verification of State Licensure from EACH jurisdiction.	YES <input type="checkbox"/> NO <input type="checkbox"/>	<input type="checkbox"/>
E. Copies of legal documents supporting all name changes.	YES <input type="checkbox"/> NO <input type="checkbox"/>	<input type="checkbox"/>
F. If educated in foreign country and the documents necessary to evaluate applicant's practical training and education are not in English: Applicant shall arrange for translation of said documents into English.	YES <input type="checkbox"/> NO <input type="checkbox"/>	<input type="checkbox"/>
G. Not applicable.	YES <input type="checkbox"/> NO <input type="checkbox"/>	<input type="checkbox"/>
H. Not applicable.	YES <input type="checkbox"/> NO <input type="checkbox"/>	<input type="checkbox"/>

Section 4. PREVIOUS NAMES

If your name has changed at any point since you first attended college or university, you must provide a copy of a legal name change document for EACH time that it has changed. Acceptable documents for individuals are marriage certificates, divorce decrees, or court orders.

Changed to current name by: Marriage Divorce Court Order Spouse Death Certificate

FIRST NAME MI LAST NAME SUFFIX

Changed to current name by: Marriage Divorce Court Order Spouse Death Certificate

FIRST NAME MI LAST NAME SUFFIX

Changed to current name by: Marriage Divorce Court Order Spouse Death Certificate

FIRST NAME MI LAST NAME SUFFIX

Changed to current name by: Marriage Divorce Court Order Spouse Death Certificate

FIRST NAME MI LAST NAME SUFFIX

Section 5A. HOME ADDRESS

Even if you have a PO Box, a street address should also be provided, if applicable.

APARTMENT SUITE FLOOR PO BOX NUMBER _____

HOME STREET ADDRESS 1 (If applicable, use this line for additional building information. Otherwise, use this line to indicate STREET NUMBER and STREET NAME)

HOME STREET ADDRESS 2 (If additional space is needed, use this line to indicate STREET NUMBER and STREET NAME)

CITY

STATE ZIP CODE + 4

HOME PHONE NUMBER HOME FAX NUMBER

Section 5B. BUSINESS ADDRESS

Please note: This information will be made available to the public.

COMPANY NAME

APARTMENT SUITE FLOOR PO BOX NUMBER _____

BUSINESS STREET ADDRESS 1 (If applicable, use this line for additional building information. Otherwise use this line to indicate STREET NUMBER and STREET NAME)

BUSINESS STREET ADDRESS 2 (If additional space is needed, use this line to indicate STREET NUMBER and STREET NAME)

CITY

STATE ZIP CODE + 4

BUSINESS PHONE NUMBER BUSINESS FAX NUMBER

Section 5C. PREFERRED MAILING ADDRESS

Indicate your preferred mailing address by placing an "X" in the appropriate box. This will be the address to which all future licensing documents will be mailed. The address that will appear on your license will be your business address.

HOME BUSINESS

SECTION 7. QUESTIONS – Applicants MUST answer all of the following questions.

Please answer all of the following questions by placing an "X" in the appropriate boxes. If you answer "Yes" to questions B through J below, you must provide full information and complete details on a separate sheet of paper, including copies of relevant court documents, and attach to this application.

HPLA ONLY

Clean Hands Before Receiving a License or Permit Act of 1996 Certification Form Requirement.

Please read the information below carefully before responding to this yes or no question, as any false information provided requires that the Department of Health proceed immediately to revoke your License or Permit for which you are now applying, and fine you one thousand dollars (\$1,000.00), pursuant to D.C. Official Code § 47-2864 (2001).

IF YOU ANSWER "YES" TO THIS QUESTION, PLEASE SUBMIT PROOF OF THE ARRANGEMENTS YOU HAVE MADE TO PAY THE OUTSTANDING DEBT. IF YOU DO NOT HAVE AN APPROVED PAYMENT SCHEDULE TO PAY THE AMOUNT YOU OWE OR IF NO APPEAL IS PENDING, THE LAW REQUIRES THAT YOUR NEW LICENSE APPLICATION BE DENIED.

As of this date, do you owe more than one hundred dollars (\$100.00) to the District of Columbia Government as a result of any of the following:

Yes No

- A.
1. Fines, penalties, or interest assessed pursuant to D.C. Official Code Title 8, Chapter 8 (Litter Control Administrative Act of 1985);
 2. Fines or interest assessed pursuant to D.C. Official Code Title 8, Chapter 9 (Illegal Dumping Enforcement Act of 1994);
 3. Fines, penalties, or interest assessed pursuant to D.C. Official Code Title 2, Chapter 18 (Civil Infractions Act of 1985);
 4. Past due taxes;
 5. Past due District of Columbia Water and Sewer Authority service fees; or
 6. Fines or penalties assessed pursuant to D.C. Official Code Title 50, Chapter 23 (Traffic Adjudication)?

YES NO

The information presented above is in compliance with the requirement to submit with your application for licensure or permit under the Clean Hands Before Receiving a License or Permit Act of 1996, effective May 11, 1996 (D.C. Law 11-118, D.C. Code §47-2861 et seq.).

B.	Have you ever been convicted or investigated of a crime or misdemeanor (other than minor traffic violations) not previously reported to the Board?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	<input type="checkbox"/>
C.	Are you now or have you ever been licensed in DC or any other state/jurisdiction? (If "Yes," be sure to complete Section 6C of this form.)	YES <input type="checkbox"/>	NO <input type="checkbox"/>	<input type="checkbox"/>
D.	Have you ever been party to a malpractice action or had a malpractice action brought against you?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	<input type="checkbox"/>
E.	Have you ever voluntarily surrendered a license after formal charges have been filed against you or while under investigation?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	<input type="checkbox"/>
F.	Have you ever been terminated from or resigned from a clinical or professional training program?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	<input type="checkbox"/>
G.	Do you have a physical or medical condition that currently impairs your ability to practice your profession?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	<input type="checkbox"/>
H.	Has the use of drugs and/or alcohol resulted in an impairment of your ability to practice your profession?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	<input type="checkbox"/>
I.	(1) Have you withdrawn an application (in D.C. or any other state/jurisdiction) to practice your profession? (2) Has any authority or peer review board taken adverse action against your license or privileges? (3) Are you currently under investigation or were you investigated by any authority or peer review board for any violation of state, federal, or local law? (4) Has any authority or peer review board informed you of any pending charges(s) or investigation not previously reported to this Board?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	<input type="checkbox"/>
J.	Have you ever been terminated or asked to resign from employment since obtaining your (professional) license?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	<input type="checkbox"/>

SECTION 8. LICENSEE APPLICATION ATTESTATION AND SIGNATURE

I hereby attest that the information given in this application, including all writings and exhibits attached hereto, is true and complete to the best of my knowledge. I understand that the making of a false statement on this application, including all writings and exhibits attached hereto, is punishable by criminal penalties.

HPLA ONLY

LICENSEE SIGNATURE

NAME (Please Print)

DATE

To report waste, fraud, or abuse by any DC Government office or official, call the DC Inspector General at 1-800-521-1639.