



# 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Please note that once submitted, an application cannot be withdrawn without the approval of the State Medical Board of Ohio.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.

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. Failure to submit all required information and documentation will result in processing delays.

Attachments:

*Revised 1/4/12*

## MESSAGE 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 – MESSAGE 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. 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). If you answer yes to Question 14, you must complete and submit the Criminal Offense Information form. You must also submit 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.
  - Enclose the application fee of **\$150.00**. Make check or money order payable to **Ohio Treasurer**. *Fees are neither refundable nor transferable. DO NOT SEND CASH!*
  - BCI&I AND FBI BACKGROUND CHECKS** - Request a criminal records check from the Ohio BCI&I and FBI (refer to the Criminal Records Check instruction sheet for additional information).
  - FORM 1 – CERTIFICATE OF RECOMMENDATION** - Attach a recent (taken within the last six months) 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, 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.
  - 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 to practice massage therapy or other health professions, whether now current or not. (Examples include but are not limited to: MT, LMT, STNA, RN, LPN, and any other professional license)
  - Enclose a photocopy of your massage therapy diploma.
  - Request your Massage and Bodywork Licensing Exam (MBLEx) score sheet. If you have taken the exam more than once, please request a score sheet for each attempt.
  - Please make sure that you print your name and date the bottom of each page of the application in the space provided.

Revised 1/4/12

## 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 **Ohio Treasurer**, 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&I and FBI (refer to the Criminal Records Check instruction sheet for additional information).
4. Request your Massage and Bodywork Licensing Exam (MBLEx) score sheet from the Federation of State Massage Therapy Boards (FSMB). If the exam has been taken more than once, request a score sheet for each attempt.
5. Attach a recent (taken within the last six months) passport-type **COLOR** photo to each of the two Certificates of Recommendation (Form 1), sign your name and indicate the date your photo was taken 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.
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. **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.

9. Mail your completed application and fee directly to the State Medical Board of Ohio 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 one to two weeks after licensure. Hospitals, insurance companies, etc., must obtain verification of your Ohio license directly from the Ohio eLicense website at <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**  
**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 (BCI&I) 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&I. 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&I 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&I 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 (BCI&I 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&I 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&I and FBI.**

**Steps for “WebCheck”**

- Identify a “**BCI&I 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&I 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. Ohio forms must be used. The Board will mail the forms needed for your fingerprints to be processed at your local law enforcement agency.



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## APPLICATION FOR CERTIFICATE TO PRACTICE A LIMITED BRANCH OF MEDICINE

### MESSAGE 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.

<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> <u>IMPORTANT</u> 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>Email Address</b>	_____		
<b>Telephone Number</b>	area code & number Business: (____) _____		area code & number Home: (____) _____
	<b>Birth Date</b> month/day/year / /	<b>Birth Place</b>	City State Country
<b>High School</b>	Name of School		City Date of Graduation
<b>High School Equivalent</b>	Type		Date of Completion
<b>Gender</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female      For statistics only (optional)		



## Massage Therapy Resume of Activities

List **ALL** activities in chronological order for the last five years, 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. **DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS FORM.** If additional space is needed, please attach separate sheets.

From Month/Year <hr style="width: 80%; margin: 0 auto;"/> / <hr style="width: 80%; margin: 0 auto;"/> To Month/Year <hr style="width: 80%; margin: 0 auto;"/> /	Employer or Non-working Activity  <hr style="border: none; border-top: 1px solid black; margin: 5px 0;"/> Complete Street Address  <hr style="border: none; border-top: 1px solid black; margin: 5px 0;"/> Number & Street  <hr style="border: none; border-top: 1px solid black; margin: 5px 0;"/> City <span style="float: right;">State/Country</span> <span style="float: right;">Zip Code</span>	Position
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From Month/Year <hr style="width: 80%; margin: 0 auto;"/> / <hr style="width: 80%; margin: 0 auto;"/> To Month/Year <hr style="width: 80%; margin: 0 auto;"/> /	Employer or Non-working Activity  <hr style="border: none; border-top: 1px solid black; margin: 5px 0;"/> Complete Street Address  <hr style="border: none; border-top: 1px solid black; margin: 5px 0;"/> Number & Street  <hr style="border: none; border-top: 1px solid black; margin: 5px 0;"/> City <span style="float: right;">State/Country</span> <span style="float: right;">Zip Code</span>	Position
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From Month/Year <hr style="width: 80%; margin: 0 auto;"/> / <hr style="width: 80%; margin: 0 auto;"/> To Month/Year <hr style="width: 80%; margin: 0 auto;"/> /	Employer or Non-working Activity  <hr style="border: none; border-top: 1px solid black; margin: 5px 0;"/> Complete Street Address  <hr style="border: none; border-top: 1px solid black; margin: 5px 0;"/> Number & Street  <hr style="border: none; border-top: 1px solid black; margin: 5px 0;"/> City <span style="float: right;">State/Country</span> <span style="float: right;">Zip Code</span>	Position
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From Month/Year <hr style="width: 80%; margin: 0 auto;"/> / <hr style="width: 80%; margin: 0 auto;"/> To Month/Year <hr style="width: 80%; margin: 0 auto;"/> /	Employer or Non-working Activity  <hr style="border: none; border-top: 1px solid black; margin: 5px 0;"/> Complete Street Address  <hr style="border: none; border-top: 1px solid black; margin: 5px 0;"/> Number & Street  <hr style="border: none; border-top: 1px solid black; margin: 5px 0;"/> City <span style="float: right;">State/Country</span> <span style="float: right;">Zip Code</span>	Position
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From Month/Year <hr style="width: 80%; margin: 0 auto;"/> / <hr style="width: 80%; margin: 0 auto;"/> To Month/Year <hr style="width: 80%; margin: 0 auto;"/> /	Employer or Non-working Activity  <hr style="border: none; border-top: 1px solid black; margin: 5px 0;"/> Complete Street Address  <hr style="border: none; border-top: 1px solid black; margin: 5px 0;"/> Number & Street  <hr style="border: none; border-top: 1px solid black; margin: 5px 0;"/> City <span style="float: right;">State/Country</span> <span style="float: right;">Zip Code</span>	Position
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Applicant Name (print clearly): \_\_\_\_\_

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

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

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

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

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

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

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

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 #8 on the Application Instructions page.

(Please place a  in the yes or no box)

		<b>YES</b>	<b>NO</b>
1.	Have you ever withdrawn or been terminated from any massage therapy school, apprenticeship or course of instruction related to massage therapy?	<input type="checkbox"/>	<input type="checkbox"/>
2.	Have you ever resigned from a massage therapy school, apprenticeship or course of instruction related to massage therapy?	<input type="checkbox"/>	<input type="checkbox"/>
3.	Have you ever been disciplined by a massage therapy school, apprenticeship or course of instruction related to massage therapy?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
8.	Has any licensing board or agency, including those in Ohio, ever denied you a certificate or license?	<input type="checkbox"/>	<input type="checkbox"/>
9.	Has any licensing board or agency, including those in Ohio, ever refused you a renewal or reinstatement of a certificate or license?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
12.	Has any licensing board or agency, including those in Ohio, revoked, suspended or restricted your license or placed you on probation?	<input type="checkbox"/>	<input type="checkbox"/>
13.	Has any licensing board or agency, including those in Ohio, reprimanded, fined, disciplined, requested or accepted surrender of your license?	<input type="checkbox"/>	<input type="checkbox"/>

Applicant Name (print clearly): \_\_\_\_\_

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

		YES	NO
14.	<p>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? <b>(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.)</b></p> <p>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.</p>	<input type="checkbox"/>	<input type="checkbox"/>
<b><i>For questions 15-19, if you are less than 23 years of age, please do <u>not</u> include information prior to age 18</i></b>			
15.	<p>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?</p>	<input type="checkbox"/>	<input type="checkbox"/>
16.	<p>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?</p>	<input type="checkbox"/>	<input type="checkbox"/>
17.	<p>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?</p>	<input type="checkbox"/>	<input type="checkbox"/>
18.	<p>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?</p> <p>If the answer is yes, please provide a letter from your treating physician regarding your ability to practice massage therapy safely and competently.</p>	<input type="checkbox"/>	<input type="checkbox"/>
19.	<p>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?</p> <p>If the answer is yes, please provide a letter from your treating physician regarding your ability to practice massage therapy safely and competently.</p>	<input type="checkbox"/>	<input type="checkbox"/>
20.	<p>Have you ever been diagnosed as having, or have you been treated for, pedophilia, exhibitionism, voyeurism or other sexual behavior disorder?</p>	<input type="checkbox"/>	<input type="checkbox"/>
<b><i>If you have authority to prescribe, please answer questions 21 a - d. All other applicants proceed to the signature line.</i></b>			
21.	<p>a. Are you currently registered with the Drug Enforcement Agency (DEA)?</p> <p>If yes, provide DEA number: _____</p>	<input type="checkbox"/>	<input type="checkbox"/>
	<p>b. If you are not currently registered with the DEA, have you been registered in the past?</p> <p>If yes, provide DEA number(s): _____</p>	<input type="checkbox"/>	<input type="checkbox"/>
	<p>c. Have you ever been denied a DEA registration?</p>	<input type="checkbox"/>	<input type="checkbox"/>
	<p>d. Have you ever had a DEA registration restricted, limited, revoked or suspended?</p>	<input type="checkbox"/>	<input type="checkbox"/>

Applicant Name (print clearly): \_\_\_\_\_

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 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			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

### NOTARY SEAL

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

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



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## MASSAGE THERAPY FORM 1 - CERTIFICATE OF RECOMMENDATION

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**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

### NOTARY SEAL

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

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



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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

### SCHOOL SEAL

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

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

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

\_\_\_\_\_  
Position



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## 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 to practice massage therapy, cosmetic therapy or other health professions, 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 disciplined 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

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

**AFFIX BOARD SEAL  
(NOT VALID WITHOUT SEAL)**

**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

**APPLICATION – CERTIFICATE TO PRACTICE MASSAGE THERAPY  
CRIMINAL OFFENSE INFORMATION**

This form must be completed 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: \_\_\_\_\_ Specify  Other: \_\_\_\_\_ Specify

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

\_\_\_\_\_  
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\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

\_\_\_\_\_  
Date