

FLORIDA BOARD OF MASSAGE THERAPY

Application for Apprenticeship With instructions



**Board of Massage Therapy
4052 Bald Cypress Way, Bin # C-06
Tallahassee, FL 32399-3256
(850) 488-0595
WWW.FLHEALTHSOURCE.COM**

October 2010 Edition

- You must retain the application instructions for your records. Do not send them to the Board Office with your application.
- Make a copy of everything you send to the Board Office for your own records. You may need to reference it during the application process.
- Mail the completed ORIGINAL application and fees to the Department of Health at the address listed in the instructions below.
- Read the entire application package. Most questions will be answered by reading the enclosed instructions and application.

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Before the apprenticeship program may begin, it must be-

- Approved by the Board of Massage Therapy and the apprenticeship license received by the apprentice.
- Under the **direct supervision** of a sponsoring massage therapist who has been licensed for **at least** three years. Conducted in a **licensed massage establishment**. The establishment **MUST** be inspected prior to the commencement of the program to determine compliance with the requirements as set forth in Rule 64B7-29.001(5) F.A.C.

Before The Apprentice Can Apply For a Full Massage Therapist License, The Applicant Must-

- Contact one of the following examination vendors-
 - The National Certification Board for Therapeutic Massage and Bodywork examination (NCBTMB)
 - The National Certification Exam for Therapeutic Massage (NCETM)
 - National Exam for State Licensure (NESL) administered by NCBTMB
 - The Massage and Bodywork Licensing Examination (MBLEX) administered by the Federation of State Massage Therapy Boards
- File an application for licensure with the Board of Massage Therapy, along with the initial licensure fee of \$205.00.

INSTRUCTIONS FOR COMPLETING THE APPRENTICE APPLICATION

Where to send the application- The original application accompanied by the applicable fee should be addressed to the following-

Department of Health
Payment Management
P.O. Box 6330
Tallahassee, FL 32399-6330

Where to send any additional documentation- Any additional documentation, sent either by the applicant or by any other source on your behalf, should be mailed to the following address-

Department of Health
Board of Massage Therapy
4052 Bald Cypress Way, BIN C06
Tallahassee, FL 32399-3256

Carefully read the instructions before completing the APPRENTICESHIP APPLICATION.

1. **Name-** List Last, First, and Middle name as it would appear on a birth certificate and/or legal name change document. Nicknames or shortened versions are unacceptable.
2. **Mailing Address-** List the address where correspondence regarding your application should be received. If you should move during the application process, please notify our office immediately in writing of your new address.
3. **Physical Address-** If your mailing address is a Post Office Box, please provide the physical location address of your residence.
4. **Home and Business Telephone number-** Provide telephone numbers at which you may be reached.
5. **Change of Name-** If you have legally changed your name through marriage or action of the court, submit all names in which you have been known
6. **Demographic information-** We are required to ask that you furnish the following information as part of your voluntary compliance with Section 2, Uniform Guidelines on Employee Selection Procedure (1978) 43 FR38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.
7. **License verification-** You must also request an official license verification(s) to be submitted to the Board directly from all State licensing boards in which you hold, or have held **any regulated professional license**. The official licensure verification must state the following-
 - Current status
 - Method of licensure (exam or endorsement)
 - Date of original licensure
 - Any discipline; if license has been disciplined please request the licensing state send directly to the board office all official disciplinary documentation
8. **Disciplinary History-** Answer yes or no. If you have ever had discipline on a license you must submit a self-explanation and letters of recommendation as described below in the criminal history section
9. **Criminal History documentation** – If you answered yes to any of the criminal history questions on the application you will need to send in the following-
 - Self-explanation- A brief, legible explanation of the events and what you are doing to insure they do not occur again
 - Final Disposition- This may be obtained from the clerk of court in the county the offense occurred. You must submit this document for each offense
 - Letters of Recommendation- 3-5 professional letters of recommendation, these letters should come from supervisors or teachers. Letters from family, friends or co-workers are not considered professional

10. Pursuant to Section 456.0635(2), Florida Statutes, the following questions are being asked. If you answer “Yes” to any of the following questions, explain on a separate sheet providing accurate details and submit copies of supporting documentation.

11. Health History Documentation-

- Self-explanation as described above in the criminal history section
- Letter from your physician(s) or other health care worker stating your current status and ability to practice massage therapy

If you answered “yes” to an applicant history question on your application, your application may be presented to the Board for determination of licensure. Once an application is complete, it is forwarded to the designated Board member for determination as whether your application would need to be presented to the Board. Board staff cannot make this determination. If your application has to be presented to the Board you will be notified in writing with the date and time of the next board meeting.



State Of Florida Application For Licensure
 Massage Therapist Apprentice
 Department Of Health
 Board Of Massage Therapy
 4052 Bald Cypress Way, Bin C06
 Tallahassee, Florida 32399-3256
 (850) 488-0595

Massage Therapy Apprenticeship \$100

1. Name	(First)	(Middle Initial)	(Last)
2. Mailing Address	(Street number & Name)		
	(City, State & Zip Code)		

3. Physical Address May be the same as the Mailing Address	(Street number & Name)
	(City, State & Zip Code)

4. Phone Numbers	(Home Phone Number)
	(Business Phone Number)

E-Mail Notification: If you want to be notified of the status of your application by e-mail please check the yes box and write your e-mail address on the line provided below. If you chose this form of notification you will receive information regarding your application file through e-mail only. You will be responsible for checking your e-mail regularly and updating your e-mail address with the Board office at: mqa_massagetherapy@doh.state.fl.us

I want to be notified by E-Mail only Yes No

E-Mail Address: _____

5. List any other names by which you have been known in the past.

6. We are required to ask that you furnish the following information as part of your voluntary compliance with Section 2, Uniform Guidelines on Employee Selection Procedure (1978) 43 FR38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

Date Of Birth (Month/Day/Year)	Sex- <input type="checkbox"/> Female <input type="checkbox"/> Male
Race	<input type="checkbox"/> White <input type="checkbox"/> Hispanic

Native American

Black

Asian/Pacific Islander

Other-

7. Please list any licenses or certifications, regardless of status, to practice any profession in any state-

8. DISCIPLINARY HISTORY *Attach additional sheets, if necessary*

A. Yes No Have you ever been denied or is there now any proceeding to deny your application for any healthcare license to practice in Florida or any other state, jurisdiction or country?

B. Yes No Have you ever had disciplinary action taken against your license to practice any healthcare related profession by the licensing authority in Florida or in any other state, jurisdiction or country?

C. Yes No Have you ever surrendered a license to practice any healthcare related profession in Florida or in any other state, jurisdiction or country while any such disciplinary charges were pending against you?

D. Yes No Do you have any disciplinary action pending against your license?

9. CRIMINAL HISTORY (Review Questions & Answers section in instructions)

A. Yes No Have you **EVER** been convicted of, or entered a plea of guilty, nolo contendere, or no contest to, a crime in any jurisdiction other than a minor traffic offense? You must include all misdemeanors and felonies, even if adjudication was withheld. **Driving under the influence (DUI) or driving while impaired (DWI) is not a minor traffic offense for purposes of this question.**

B. Yes No Have charges ever been brought against you by any branch of the United States Armed Services

10. Pursuant to Section 456.0635(2), Florida Statutes, the following questions are being asked. If you answer "Yes" to any of the following questions, explain on a separate sheet providing accurate details and submit copies of supporting documentation.

1a. Yes No Have you been convicted of, or entered a plea of guilty or nolo contendere, regardless of adjudication, to a felony under Chapter 409, Chapter 817, or Chapter 893, Florida Statutes; or 21 U.S.C. ss. 801-970 or 42 U.S.C. ss. 1395-1396?

b. Yes No Has it been more than 15 years prior to the date of this application since the sentence and completion of any subsequent period of probation for such conviction?

2a. Yes No Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes?

b. Yes No If the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant has been terminated, has the applicant been reinstated and in good standing with the Florida Medicaid Program for the most recent five years?

3a. Yes No Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant ever been terminated for cause, pursuant to the appeals procedures established by the state or federal government, from any other state Medicaid program or the federal Medicare program?

b. Yes No Has the applicant been in good standing with a state Medicaid program or the federal Medicare program for the most recent five years?

c. Yes No Did the termination occur at least 20 years prior to the date of this application?

To Be Completed By The Establishment Owner

A.) Is your establishment equipped with tables for massage therapy?

Yes
 No

B.) Is your establishment equipped with linen and storage areas?

Yes
 No

C.) Is your establishment equipped with Hot and Cold packs?

Yes No

D.) Is your establishment equipped with textbooks and teaching material on the following subjects-

- Physiology Yes No
- Anatomy Yes No
- Theory of Massage Yes No
- Hydrotherapy Yes No
- Statutes and Rules on Massage Practice Yes No

E.) Will the apprentice be instructed in colonic irrigation (optional)?

Yes No

If yes, the following must be answered-

- Is your establishment equipped with sterilization equipment? Yes No
- Are disposable colonic attachment utilized? Yes No
- Is a textbook on the subject of colonic irrigation kept on the premises? Yes No

F.) Has the massage establishment, or owner, ever been convicted of a crime related to the practice of massage therapy, regardless of adjudication, or has the massage establishment license ever been disciplined, in any jurisdiction? If yes, please list and attach on additional sheets, the dates, jurisdiction, offense, disposition, and all other relevant information

Yes No

You will be inspected based on the above items. If you cannot answer "yes" to all applicable questions, you are urged to make immediate changes in order to pass inspection or delay the application for this apprentice until your facility is able to pass inspection.

I, _____, certify that _____, employed at

(Name of establishment representative)

(Name of Sponsor)

_____ establishment license #_MM_____ located at

(Name of Establishment)

_____ has my approval to sponsor

(Street Address - City, State, Zip Code, Phone #)

an apprentice at the above named establishment.

(Signature of Establishment Representative)

(Printed Name of Establishment Representative)

To Be Completed By Sponsor

A.)
I, _____, hereby certify that the previously named applicant will be associated with my practice and establishment, as an apprentice, and I will be his/her sponsor and I will comply with all requirements pursuant to Rule 64B7-29 F.A.C.

B.)
Have you, the sponsor, ever had a massage therapist license, registration or certification revoked, suspended or otherwise acted against, including probation, fine or reprimand in a disciplinary proceeding in any state?

Yes
 No

If yes, you must provide complete details as to the state(s), license number(s), dates and relevant circumstances on an attached sheet.

C.) Sponsor's Printed Name-

D.) Sponsor's License Number-

E.) Sponsor's Signature and Date

(Signature)

(Date)



CONFIDENTIAL AND EXEMPT FROM PUBLIC RECORDS
DISCLOSURE*

Florida Department of Health
Board of Massage Therapy

Name- _____
 Last **First** **Middle**

Social Security Number- _____

* This page is exempt from public records disclosure. The Department of Health is required and authorized to collect Social Security Numbers relating to applications for professional licensure pursuant to Title 42 USCS § 666 (a)(13). For all professions regulated under Chapter 456, Florida Statutes, the collection of Social Security Numbers is required by section 456.013 (1)(a), Florida Statutes.

11. HEALTH HISTORY (SUPPORTING DOCUMENTATION SHOULD BE SENT DIRECTLY TO THE BOARD OFFICE)

Supporting documentation must include a letter from the applicant explaining the medical condition(s) or occurrence(s) and current status; letter(s) from licensed professional summarizing diagnosis, treatment and prognosis; or any other official documentation as it relates to any "yes" answer. Documentation should be current within the last year.

A. Yes No In the last five years, have you been enrolled in, required to enter into, or participated in any drug or alcohol recovery program or impaired practitioner program for treatment of drug or alcohol abuse that occurred within the past five years?

B. Yes No In the last five years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental disorder or impairment?

C. Yes No During the last five years, have you been treated for or had a recurrence of a diagnosed mental disorder that has impaired your ability to practice massage therapy within the past five years?

D. Yes No During the last five years, have you been treated for or had a recurrence of a diagnosed physical disorder that has impaired your ability to practice massage therapy?

E. Yes No In the last five years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol/drug) disorder or, if you were previously in such a program, did you suffer a relapse within the last five years?

F. Yes No During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol/drug) disorder that has impaired your ability to practice massage therapy within the past five years?

I understand that it is my duty and responsibility as an applicant for licensure to supplement my application after it has been submitted if and when any material change in circumstances or conditions occur which might affect the Board's decision concerning my eligibility for examination or licensure. Such supplement is required by section 456.013(1), F.S. Failure to do so may result in disciplinary action by the Board including denial of licensure.

I have carefully read the questions in the foregoing application and have answered them completely, without reservation of any kind, and I declare that my answers and all statements made by me herein and in support of this application are true and correct. Should I furnish any false information on or in support of this application, I understand that such action shall constitute cause for denial, suspension, or revocation of any license to practice in the state of Florida in the profession for which I am applying. I hereby acknowledge that practice as a licensed Massage Therapist in Florida is governed by Chapters 456 and 480, F.S., and Rule Chapter 64B7, F.A.C. I understand that I am under a continuing obligation to understand and keep informed of any changes to Chapters 456 and 480, F.S., and Rule Chapter 64B7, F.A.C.

Applicant Signature- _____

Date Signed- _____