Arkansas Department of Health
Massage Therapy Section
4815 West Markham, Slot #8
Little Rock, AR 72205
Phone: (501) 683-1448
Fax: (501) 682-5640

School of Massage Therapy Application

Regardless of owner, each establishment with a separate address is required to make separate application. If purchasing a school, a new application with application fees must be submitted. School licenses are non-transferable. Payment must be made **by Cashier's Check or Money Order only, payable to ADH-Massage Therapy Section.**

Proposed School Information

Name of Proposed School of Massage Therapy			Date
Physical Address			Suite
City	State	Zip	County
Phone	Fax	Email	

Days Closed

☐ Sunday ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday

Opening Date_____ Hours of Operation_____

Owner Information

Owner's Name (If corporation list all owners and officers – use separate sheet if necessary)			
Mailing Address			
City	State	Zip	County
SSN or EIN	Date of Birth	Phone	

(Attach additional sheets when necessary)

1. Are you a graduate of an approved school of massage therapy? If yes, give name and address of school, name and phone number of contact person.

_____

_____

2. Date of Graduation: _____

3. Attach a copy of your massage school diploma and your current license.

4. If the school you attended is no longer in operation, give the name and address of the person(s) who have access to the school records.

_____

_____

5. Are you currently or ever been licensed to practice massage therapy or therapy technology in another state? If yes, provide location, dates of licenses and copy of licenses.

_____

_____

6. Provide a resume' of your education, i.e. High School, High School Equivalency, College, and/or Graduate School. Attach documentation.

_____

_____

7. List previous employers for the past ten (10) years. Include complete address, telephone, employer/supervisor, how long employed, and reason for leaving.

_____

_____

8. Are you a resident of Arkansas?_____How long? _____

9. Previous residence address _____

_____

10. How long were you a resident of your previous address? _____

11. Attach four Letters of Recommendation from persons who are not clients or relatives and not affiliated with your business or proposed school.

12. State why you feel you are qualified to own and teach if applicable, in a school of massage therapy?

_____

_____

13. Describe the location of your school, structure, etc. and furnish a photograph of the structure.

_____

_____

14. Describe in detail the equipment available for instructional purposes and the modalities you will use for instruction.

_____

15. Submit the complete course to be used for instruction. Include textbooks and any other material you will use for instructional purposes.

_____

_____

16. List any employees or members of your staff and their qualifications. Attach any licenses that may be applicable.

_____

_____

17. Submit all forms to be used in maintain the schools records of students.

18. Submit all examinations you plan to give prior to the state board exam.

19. Submit a copy of your school's catalog.

20. Do you have a physician on call for your school? If yes, give name and address of physician.

_____

_____

21. What is your refund policy? (Explain in detail)

_____

_____

22. Are you prepared for an inspection of your school by a member of the Arkansas State Board of Massage Therapy? If not, provide date you will be prepared.

_____

_____

Registration Fees
(<u>Cashier's Check or Money Order ONLY</u>)

New school registration fee $850.00

Satellite school registration fee $425.00

Personal Background/Criminal History – Please Check (attach additional sheets if necessary)

This application, all documents attached, and seven additional copies of the application and all documents must be submitted to the Section's office 30 days prior to a regularly scheduled meeting of the Department. A cashier's check or money order payable to ADH-Massage Therapy Section for registration fees shall accompany the original application.

All statements made in this application are subject to investigation after the application is presented to the Department. Any additional information requested by the Department will be submitted within 90 days. After presentation of the application to the Department, applications will be duly processed and investigations instituted. All school applications will be investigated thoroughly.

In as much as the present Department is continually upgrading the massage therapy practice of this state, all questions must be answered fully and accurately.

The Department members retain the right to visit during class hours and lecture sessions at their discretion and without notification.

Certificate of Moral Character

The individuals named below must not be in a supervisory capacity to the application, a present employee, or one who might possibly be an employee.

This certifies that I am personally acquainted with_____and that I know him/her to be of good moral character.

_____	_____
Signature	Signature
_____	_____
Printed Name	Printed Name
_____	_____
Address	Address
_____	_____
City, State, Zip	City, State, Zip
_____	_____
Phone	Phone

Affidavit with Acknowledgment
(Notarization required)

I (We) declare and affirm that the statements made in this application and any accompanying documents, are true, complete and correct. I understand that any false or misleading information in, or in connection with, this application may be cause for denial or loss of licensure and may result in criminal prosecution.

_____ _____
Signature of Owner/Administrator/Officer Date

_____
Title

_____ _____
Signature of Owner/Administrator/Officer Date

_____
Title

_____ _____
Signature of Owner/Administrator/Officer Date

_____
Title

_____ _____
Signature of Owner/Administrator/Officer Date

_____
Title

NOTARY

STATE OF _____

COUNTY OF _____

Signed and sworn to before me this_____day of_____, 20_____

by_____, who personally appeared before me.

_____ (SEAL)
Notary Public Signature

_____
Notary Commission Expiration Date

Revised 10.1.15