Department of Health

Maryland State Board of Massage Therapy Examiners

4201 Patterson Avenue, Suite 301
Baltimore, Maryland 21215
Office Main Telephone: 410-764-4738 • Office Fax: 410-358-1879

REACTIVATION APPLICATION 2016-2018

(Only For Licenses / Registrations Expired 24 Months or Less)

NOTE: IF YOU ARE NOT SURE OF YOUR LICENSE / REGISTRATION STATUS, ACCESS THE '*VERIFICATION*' LINK ON THE BOARDS OFFICIAL WEBSITE:
www.health.maryland.gov/massage

REACTIVATION FEES:

LICENSE MASSAGE THERAPIST =L.M.T. **REGISTERED MASSAGE PRACTITIONER = R.M.P.**

Payment must be by personal check, certified check, or money order payable to ***'MD State Board of Massage Therapy Examiners'*** and MAILED TO: **4201 Patterson Avenue, Suite 301, Baltimore, MD 21215,** Attn: **Adrienne Congo, MS, Deputy Director**

◆ **REACTIVATION Application Fees for (LMT) – $376.00** (Includes $100 reactivation fee, $250 renewal fee, and the mandatory assessment of $26 by the Maryland Health Care Commission which applies to all Maryland Health Care Practitioners (LMT's only). Other requirements apply > see page 2.

◆ **REACTIVATION Application Fees for (RMP) – $350.00** (Includes $100 reactivation fee and $250 renewal fee.

To further its commitment to equal opportunity, the Board of Chiropractic & Massage Therapy Examiners request applicants to provide VOLUNTARILY, the following information. This information will be used for statistical purposes only by authorized personnel.

Race/ethnic identification – please check all that apply:

☐ 1. Hispanic or Latino origin (a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race).
☐ 2. American Indian or Alaska Native (a person having origins in any of the original peoples of North or South America, including Central America, and who maintain affiliations or community attachment).
☐ 3. Asian (a person having origin in any of the original peoples of the Far East, Southeast Asia or the Indian subcontinent including, for ex. Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam).
☐ 4. Black or African American (a person having origins in any of the black racial groups of Africa).
☐ 5. Native Hawaiian or other Pacific Islander (a person having origins in the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands).
☐ 6. White (a person having origins in any of the original peoples of Europe, the Middle East or North Africa).
☐ 7. Other
☐ 8. Prefer Not to Answer
☐ 9. U.S. Military Service

Gender ☐ **Male** ☐ **Female** ☐ **Other**

INFORMATION ON FILE WITH THE BOARD

COMPLETE THE FOLLOWING INFORMATIONAL SECTIONS WITH LEGAL AND ACCURATE INFORMATION. THIS IS A FILLABLE PDF OR PRINT LEGIBLY OR TYPE.
FAILURE TO PROVIDE UPDATED INFORMATION PER INSTRUCTIONS ON THIS APPLICATION WILL RESULT IN THIS APPLICATION BEING RETURNED TO YOU.

☐ **MY NAME HAS LEGALLY CHANGED – ATTACH NAME CHANGE FORM** ☐ **MY ADDRESS HAS CHANGED - ATTACH ADDR. CHANGE**

FULL NAME: _____ **CONTACT PHONE:** _____

LEGAL ADDRESS (*include apt#, suite #'s*)**:** _____

CITY: _____ **STATE:** _____ **ZIP:** _____ **E-MAIL:** _____

(A). WORKERS' COMPENSATION INSURANCE INFORMATION *(Required per Health Occupations Art. §1-202): Please direct inquiries to 410-864-5100 or visit the WCC website at http://www.wcc.state.md.us for more info.*

I HEREBY CERTIFY THAT: (Check One)

☐ do not practice in Maryland. ☐ practice in Maryland and am **NOT** an employer. ☐ practice in Maryland and employ one or more persons.

Listed below is my required Workers' Compensation Insurance information.

Insurance Co.: _____ Policy No.: _____ Exp. Date: _____

NOTE: YOU MAY NOT PRACTICE MASSAGE THERAPY UNTIL YOU HAVE THE VALID BOARD ISSUED LICENSE OR REGISTRATION

(B). PROFESSIONAL COMPETENCY & BACKGROUND

Please write "***YES***" or "***NO***" to each question below. All "*yes*" answers must be explained in your own words on a separate sheet. Include all details, dates, and resolutions to the matter. ***NOTE*: ALL QUESTIONS MUST BE ANSWERED OR APPLICATION WILL BE RETURNED.**
PROVIDE ACCURATE, COMPLETE AND COMPREHENSIVE ANSWERS TO AVOID DELAYS OR SANCTIONS.

_____ **1.** ***Since your last active status***, have you been addicted to, or is currently dependent on alcohol, any drug (prescription or non-prescription), or any controlled substance?

_____ **2.** ***Has ANY state*** licensing, certification or disciplinary Board or comparable body in any federal, state, municipal or Armed Forces ever taken any action against your license, certification, or registration, including this Board?

_____ **3.** ***Since your last active status***, have there been any outstanding complaints, investigations, charges, or allegations pending against you by any of the aforementioned bodies?

_____ **4.** ***Since your last active status***, have you had a physical or mental illness, or injury/disability that impaired or impairs your ability to practice?

_____ **5.** ***Since your last active status*, have you** *had any* ***court proceedings,*** pled ***guilty***, ***nolo contendere***, ***no contest***, or been ***convicted*** or received ***probation before judgment*** of any criminal act, including DWI or DUI of alcohol or controlled substances?

_____ **6.** ***Since your last active status***, has any hospital, HMO, managed care organization, or related healthcare entity or employer denied you privileges or employment, denied application for employment, or did not renew your contract for a reason or reasons related to your practice?

_____ **7.** ***Since your last active status***, has a malpractice civil suit, civil suit or action been filed against you or has a claim been made against you or a settlement or award had been made against you relating to your practice?

(C). CONTINUING EDUCATION (*TOTAL REQUIRED* = 24 Hours) & CPR CERTIFICATION: New revised regulations – Jan. 6, 2014 are: 1 hour in diversity and Cultural Competency + 3 hours in Professional Ethics or Jurisprudence + 3 hours in Communicable Diseases including AIDS/HIV + 17 Massage Related (techniques) courses = 24 CEUS.

You must remit with your application, **copies** of your CEU certificates (dated November 1st through October 31st of the biennial window [the dates after the last expiration of your last active license/registration]) AND a **copy** of your current valid qualification in CPR along with this Reactivation Application. **Reactivation forms submitted WITHOUT copies of valid CEU completion certificates and a copy of your active CPR (Healthcare Provider Level) for LMTs or card (front/back); WILL NOT BE PROCESSED and will be returned to you for resubmission.**

(D).

Active **LMT** Fee: **$276.00** (*Renewal Fee Includes Health Care Commission Fee of $26.00)* **$** _____
Active **RMP** Fee: **$250.00** **$** _____

Reactivation Fee: **$100.00 (***In addition to the above renewal fee)* **$** _____

Duplicate Request Fee: **$40.00** X _____ (*$20.00 during Biennial Renewal Period – Aug. 30th – Nov. 30th even yr.*)**$** _____
Check(s) or money order(s) number(s): _____ **TOTAL FEES $** _____

I AFFIRM AND ATTEST THAT THE INFORMATION I HAVE GIVEN ON THIS APPLICATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

PRINT/TYPE APPLICANT FULL NAME	APPLICANT SIGNATURE	LIC. / REG. No.	DATE
_____	_____	_____	_____

BOARD OFFICE USE ONLY	
CHRC UNIT: Investigator Sign Off: _____	Date Received to Office: _____ Review Date: _____ Int.: _____
	Check Date: _____ APPROVAL DATE: _____ Int.: _____
Fwd. to D & C Committee Date: _____	Check Number: _____ Entered Database: _____ Int.: _____
(If Forwarding is applicable)	Lic./Reg. Number: _____ Control #:_____ Int.: _____

Professional Competency & Background Explanation

(For yes answers to Questions 1-7 of Section B)

Note: If not applicable; disregard this page. If you answered yes; complete information or indicate specific documents you attached.