



MARYLAND STATE BOARD OF MASSAGE THERAPY EXAMINERS
4201 Patterson Avenue, Suite 301, Baltimore, Maryland 21215
Office Main Telephone: 410-764-4738 • Email: mdh.bcmte@maryland.gov

REQUEST FOR APPROVAL FOR VISITING MESSAGE THERAPIST/REGISTRANT

Pursuant to COMAR10.65.01.05(B)(2), applicant must be affiliated with a visiting organization and practice massage therapy for not more than 7 consecutive days and not exceed 30 days per calendar year.

The individual must complete this form and submit the following to the Board:

- **\$100.00 Application Fee payable to the MD State Board of Massage Therapy Examiners**
- Copy of current, active state massage license and a valid Government-issued id with picture (ex: Driver's License or Passport)
- Submit a copy of current provider-level CPR certification
- Attestation there are no complaints under investigation by current state Board
- Have the current state Board submit a certificate of good standing directly to the MD Board

Name: _____

Address: _____

Cell Phone(s): _____ (required) Email: _____ (required)

List all State(s) in which currently licensed and License No(s):

Visiting Organization Name: _____

Visiting Organization Address: _____

Organization's Contact Person and Phone No.: _____

Applicant's affiliation with Visting Organization: _____

Date(s) of event: _____

Location of event: _____

Are there current and/or outstanding complaints, investigations, charges or allegations pending against your license, certifications or registrations in any state? Yes No

I attest the information provided above is truthful and correct to the best of my knowledge and belief. I understand that providing false information of any kind or omitting information known to me may result in the denial of this request. I agree that all documents submitted with this request are the property of the Board and fees are non-refundable. _____ **Initials**

Signature _____

Date _____

FOR BOARD USE ONLY :
 Date Rec'd: ____ / ____ / ____ Fee _____ Check Date: ____ / ____ / ____ Check # _____
 CPR Cert.: _____ Current License(s) Copy: _____ Valid Gov. Issued ID: _____ Cert. Of Good Standing(s): _____
 Administrative Approval: _____ Date ____ / ____ / ____ Approval Letter Sent _____