MARYLAND STATE BOARD OF MASSAGE THERAPY EXAMINERS
4201 Patterson Avenue, Suite 301, Baltimore, MD 21215
Office (410) 764-4738; Email: mdh.bcmte@maryland.gov
www.health.maryland.gov/massage

REACTIVATION APPLICATION

(For Licensees / Registrants Who Completed An Inactive Status Application - Less Than 5 Years)

FEES

Payment must be by certified check, or money order payable to **MD State Board of Massage Therapy Examiners.** Mail with application to: **4201 Patterson Avenue, Suite 301, Baltimore, MD 21215.** Attention: **Licensing Unit.**

LICENSED MASSAGE THERAPIST = LMT	REGISTERED MASSAGE PRACTITIONER = RMP
$376.00 - Includes $100 reactivation fee; $250 renewal fee; and the mandatory $26 assessed by the Maryland Health Care Commission on all Maryland Health Care Practitioners.	**$350.00 -** Includes $100 reactivation fee and $250 renewal fee.

CURRENT INFORMATION ON FILE WITH THE BOARD

Name: _____ License/Registration Number: _____

Non-Public (Home) Address: _____

_____
City *State* *Zip*

Public (Business) Address: _____

_____
City *State* *Zip*

SSN/ITIN: _____ Date of Birth: _____

Home Phone:_____ Cell:_____ Business Number:_____

Personal Email: _____ Business Email: _____

Check applicable box: ☐ My name has legally changed. ☐ My address has changed.
Attach Name Change and/or Address Change form to this application.

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 information.*

I HEREBY CERTIFY THAT ***(Check One)*** ☐ I do not practice in Maryland. ☐ I practice in Maryland and am **NOT** an employer. ☐ I practice in Maryland and employ one or more persons (must provide insurance information below).

Listed below is my required Workers' Compensation Insurance information.

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

BOARD USE ONLY

Check Date: _____ Check Amt.: _____ Check Number: _____ Initials _____

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, resolutions and submit court/legal documents related to the matter.

_____ **1.** Has a state licensing or disciplinary board (including Maryland) a comparable body in the armed services or the Veterans Administration, denied your application for licensure, registration, certification, reinstatement, reactivation or renewal?

_____ **2.** Has a state licensing or disciplinary Board (including Maryland) or comparable body in the armed services or the Veterans Administration, taken action against your license, registration or certificate? Such actions include but are not limited to, limitations of practice, required education, admonishment or reprimand, suspension, probation or revocation.

_____ **3.** Has any licensing or disciplinary board in any jurisdiction (including Maryland), a comparable body in the armed services or the Veterans Administration, filed any complaints or charges against you or investigated you for any reason?

_____ **4.** Have you **ever** pled guilty, nolo contendre, no contest, or been convicted or received probation before judgment for **any** criminal act (felony or misdemeanor), including DWI or DUI, in **any** state of jurisdiction?

_____ **5.** Have you surrendered your license, registration or certificate or allowed it to lapse while you were under investigation by any licensing or disciplinary board of any jurisdiction, or any entity of the armed services or the Veterans Administration?

_____ **6.** Do you currently have any condition or impairment (including, but not limited to, substance abuse, alcohol abuse, or a physical, mental, emotional, or nervous disorder/condition) that in any way affects your ability to practice massage therapy in a safe, competent, ethical, and professional manner?

_____ **7.** Have any malpractice claims or other claims for money damage been filed against you? Include past and pending claims, dismissed or settled claims, or claims which resulted in a damages award against you.

I affirm and attest the answers provided above are true and accurate. _____
Applicant's Signature Date

B. CONTINUING EDUCATION: 24 Hours & a CPR certification completed between November 1st and October 31st of the last two years. Requirements 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.

- ☐ 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
- ☐ CPR Certification at Healthcare Provider Level

☐ Copies of all CEU certificates and unexpired CPR certificate are attached to the application._____ Applicant's Initials

C. Fees

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

Active **RMP** Renewal Fee: $250.00 $_____

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

Duplicate 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 Applicant's Name Applicant's Signature Date

REACTIVATION APPLICATION

Applicant's Name: _____ License/Registration Number:_____

Professional Competency & Character and Fitness Background Explanation

*(For "**Yes**" answers to Questions 1-7 of Section A)*

If not applicable; disregard this page. If you answered yes to any questions in Section A – page 2, complete information and indicate the specific documents you attached.