

# State Board of Massage Therapy

Phone: 717-783-7155  
Fax: 717-787-7769  
Email: [RA-massagetherapy@pa.gov](mailto:RA-massagetherapy@pa.gov)

P. O. Box 2649  
Harrisburg, PA. 17105-2649  
[www.dos.pa.gov/massagetherapy](http://www.dos.pa.gov/massagetherapy)

Courier Delivery Address:  
2601 North Third Street  
Harrisburg, PA. 17110

## MESSAGE THERAPIST LICENSURE BY EXAMINATION

### Application Instructions:

All licenses expire on January 31, of odd-numbered years, **regardless** of the date of issue. You may not practice massage therapy unless you hold a current license. You may renew your license beginning 60 days before your current license expiration date.

### CHECKLIST FOR APPLICANTS FOR LICENSURE BY EXAMINATION

\_\_\_\_\_ Complete, sign and date the application.

\_\_\_\_\_ Enclose a check or money order in the amount of \$65.00. The check or money order should be made payable to the Commonwealth of Pennsylvania. The fee is not refundable. If all materials in support of your application are not received within 6 months of the date of your signature on the application, your application will not be processed and you will have to submit another application form and fee if you still wish to obtain a license.

\_\_\_\_\_ Attach a copy of a legal form of identification, such as a driver's license, a current passport, or a valid state identification card. The copy should be submitted on an 8 ½ x 11 sheet of paper.

\_\_\_\_\_ Attach the Certification of Good Moral Character form, filled out and signed by two individuals, who are not related to you, who have known you for at least six months. At least one of the references must hold a current state massage therapy license.

\_\_\_\_\_ An official Criminal History Record Check (CHRC) from the state agency for every state in which you have resided for the past 5 years. The report(s) must be dated within 6 months of the date of your application for licensure by examination. This report can be sent to you and forwarded to the Board with your application. For Pennsylvania CHRC, this can be done online at <http://epatch.state.pa.us>. For states that do not provide CHRC for employment or licensing purposes (CA & AZ), we will accept an FBI background check.

#### **If you have a criminal record,**

- a. Attach certified court documents related to the conviction(s), and
- b. A personal statement explaining the conviction(s) and what you have done since the conviction(s) that demonstrates that you are rehabilitated.

\_\_\_\_\_ Attach a copy of the front & back of your current Adult Basic CPR certification, including the expiration date of your CPR certification. Your card must be signed and if applicable, a copy of the legend must be included. The copy should be submitted on an 8 ½ x 11 sheet of paper. **Online CPR is not acceptable.**

\_\_\_\_\_ Complete the top section of the "Verification of Massage Therapy Education" form (pages 4-5) and give the form to the Dean, Registrar or Chairperson of your Massage Therapy Program. The school must complete the bottom section and **attach a copy of your transcripts**. A qualifying program must be a minimum of 600 hours. **The school seal MUST be affixed where indicated and the ORIGINAL form returned by the school directly to the Board office in an official school envelope**. **The form must be completed AFTER you have received your certificate or degree: program completion may NOT be anticipated. Out-of-state schools will be required to submit a copy of their school certification/accreditation with the form.**

\_\_\_\_\_ You must request either FSMTB, PO Box 198748, Nashville TN 37219 (1-866-962-3926) or NCBTMB, 1901 S Meyers Road, Suite 240, Oakbrook Terrace, IL 60181 (1-800-296-0664), to have your exam scores released to the Board. This information must come directly from the testing agency to the Board.

\_\_\_\_\_ Request each state in which you now hold or ever held (active or inactive, current or expired) a permanent **massage therapy** license/certification (not a temporary) to forward a “Letter of Good Standing” **directly** to the Board office in a sealed official state board envelope.

\_\_\_\_\_ The Bureau of Professional and Occupational Affairs (BPOA), in conjunction with the Department of Human Services (DHS), is providing notice to all health-related licensees and funeral directors that are considered “mandatory reporters” under section 6311 of the Child Protective Services Law (CPSL) (23 P.S. § 6311), as amended, that EFFECTIVE JANUARY 1, 2015, all persons applying for issuance of an initial license shall be required to complete 3 hours of DHS-approved training in child abuse recognition and reporting requirements as a condition of licensure. Please review the Board website for further information on approved CE providers. Once you have completed a course, the approved provider will electronically submit your name, date of attendance, etc., to the Board. [Child Abuse Continuing Education Providers Information can be found here.](#)

### **NAME OR ADDRESS CHANGE:**

If the name you are currently using on your application is different than the name you used on any of the other documents required to be submitted with your application, or if you change your name after you submit this application, send evidence of your name change within ten (10) days. For example, send a copy of marriage certificate or court order authorizing the name change.

If your address changes after you have submitted your application, notify the Board office in writing of your name, old address and new address. Mail this information to the Board office at the address shown above within ten (10) days.

### **OTHER INFORMATION:**

If a pending application is older than six months from the date submitted online and the applicant wishes to continue the application process, the Board shall require the applicant to submit a new application including the required fee. Many of the supporting documents associated with the application also cannot be more than six months from the date of issuance. All background check documents cannot be older than 90 days from the date of issuance.

Maintain a copy of all documents sent to the Board. Send your application materials to the Board at: State Board of Massage Therapy, PO Box 2649, Harrisburg, PA 17105-2649 OR (for courier delivery) 2601 North Third St, Harrisburg, PA 17110.

You may view the Massage Therapy Law and the regulations of the Board online at [www.dos.pa.gov/massagetherapy](http://www.dos.pa.gov/massagetherapy).



- 1 Have you ever taken the National Certification Examination for Therapeutic Massage (NCETM), the National Certification Examination for Therapeutic Massage and Bodywork (NCETMB) or the Massage and Bodywork Licensure Examination (MLBEx)? If yes, give the exam MONTH and YEAR and to which STATE the results were reported. \_\_\_\_\_  Yes  No
  - 2 As required by Section 5 (a) (2) of the Massage Therapy Law, have you earned a high school diploma or equivalent?  Yes  No
  - 3 Have you had disciplinary action taken against a professional or occupational license, certificate, permit, registration or other authorization to practice a profession or occupation issued to you in any state or jurisdiction or have you agreed to voluntary surrender in lieu of discipline?  Yes  No
  - 4 Do you currently have any disciplinary charges pending against your professional or occupational license certificate, permit or registration in any state or jurisdiction?  Yes  No
  - 5 Have you withdrawn an application for a professional or occupational license, certificate, permit or registration, had an application denied or refused, or for disciplinary reasons agreed not to apply or reapply for a professional or occupational license, certificate, permit or registration in any state or jurisdiction?  Yes  No
  - 6 Have you been convicted (found guilty, pled guilty or pled nolo contendere), received probation without verdict or accelerated rehabilitative disposition (ARD) as to any criminal charges, felony or misdemeanor, including any drug law violations? NOTE: You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.  Yes  No
  - 7 Do you currently have any criminal charges pending and unresolved in any state or jurisdiction?  Yes  No
  - 8 Do you currently engage in or have you ever engaged in the intemperate or habitual use or abuse of alcohol or narcotics, hallucinogenics or other drugs or substances that may impair judgment or coordination?  Yes  No
  - 9 Have you ever had provider privileges denied, revoked, suspended or restricted by a Medical Assistance agency, Medicare, third party payor or another authority?  Yes  No
  - 10 Have you ever had practice privileges denied, revoked, suspended or restricted by a hospital or any health care facility?  Yes  No
  - 11 Do you hold, or have you ever held, a license, certificate, permit, registration or other authorization to practice a profession or occupation in any state or jurisdiction? If yes, please provide the profession and state or jurisdiction. \_\_\_\_\_  
Please do not abbreviate the profession.  Yes  No
- You must request that a Letter of Good Standing be sent from each state board office **directly** to the Board office in a sealed official envelope of that state board.
- 12 Will any documentation submitted in connection with this application be received in a name other than the name under which you are applying? If you selected "yes", please list the name or names. Submit a copy of the legal document indicating the name change (i.e., marriage certificate, divorce decree which indicates the retaking of your maiden name; legal document indicating the retaking of a maiden name, or court order).  Yes  No

**IF YOU ANSWERED YES TO ANY OF THE CRIMINAL/DISCIPLINARY ACTION QUESTION(S), PLEASE ATTACH AN 8 1/2 X 11 SHEET OF PAPER GIVING FULL DETAILS. INCLUDE COURTHOUSE CERTIFIED COPIES OF DOCUMENTS EXPLAINING SITUATION, IF APPLICABLE.**

**VERIFICATION**

NOTICE: Disclosing your Social Security Number on this application is mandatory in order for the State Boards to comply with the requirements of the Federal Social Security Act pertaining to Child Support Enforcement, as implemented in the Commonwealth of Pennsylvania at 23 Pa.C.S. § 4304.1(a). At the request of the Department of Human Services (DHS), the licensing board must provide to DHS information prescribed by DHS about the licensee, including the social security number. In addition, Social Security Numbers are required in order for the Board to comply with the reporting requirements of the U.S. Department of Health and Human Services, National Practitioner Data Bank.

**I verify that I have read and am familiar with the provisions of the Pennsylvania Massage Therapy Law and regulations of the State Board of Massage Therapy ([www.dos.pa.gov/massagetherapy](http://www.dos.pa.gov/massagetherapy)).**

I verify that this application is in the original format as supplied by the Department of State and has not been altered or otherwise modified in any way. I am aware of the criminal penalties for tampering with public records or information pursuant to 18 Pa.C.S. § 4911.

I verify that the statements in this application are true and correct to the best of my knowledge, information and belief. I understand that false statements are made subject to the penalties of 18 Pa. C.S. Section 4904 (relating to unsworn falsification to authorities) and may result in the suspension, revocation or denial of my license, certificate, permit or registration.

\_\_\_\_\_  
Printed Name of Applicant

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

# State Board of Massage Therapy

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PO Box 2649  
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Phone: 717-783-7155

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Harrisburg, PA. 17110  
Email: RA-massage@pa.gov

## Certification of Good Moral Character

To be completed by two individuals who have known you for at least six months. **At least one of the references must hold a state massage therapy license. Do not use individuals who are related to you. ORIGINAL SIGNATURES ARE REQUIRED.**

Name of Applicant: \_\_\_\_\_

I hereby certify that I have known the above applicant for at least 6 months and that the applicant is of good moral character. I recommend the applicant for a license to practice massage therapy in the Commonwealth of Pennsylvania.

I have been personally acquainted with the applicant for \_\_\_\_\_ year(s) \_\_\_\_\_ month(s).

SIGNATURE: \_\_\_\_\_ Date: \_\_\_\_\_

Print or type name as signed above: \_\_\_\_\_

State in which licensed: \_\_\_\_\_ License Number: \_\_\_\_\_  
(if applicable)

Name of Applicant: \_\_\_\_\_

I hereby certify that I have known the above applicant for at least 6 months and that the applicant is of good moral character. I recommend the applicant for a license to practice massage therapy in the Commonwealth of Pennsylvania.

I have been personally acquainted with the applicant for \_\_\_\_\_ year(s) \_\_\_\_\_ month(s).

SIGNATURE: \_\_\_\_\_ Date: \_\_\_\_\_

Print or type name as signed above: \_\_\_\_\_

State in which licensed: \_\_\_\_\_ License Number: \_\_\_\_\_  
(if applicable)

Return Completed Form to Applicant

State Board of Massage Therapy

Mailing Address: PO Box 2649 Harrisburg, PA. 17110 Phone: 717-783-7155

Courier Delivery Address: 2601 North Third Street Harrisburg, PA. 17110 Email: RA-massagetherapy@pa.gov

VERIFICATION OF MASSAGE THERAPY EDUCATION

Applicant: Complete (by typing/printing in blue/black ink) top section and send the 2 page form to your Massage Therapy program to complete and attach your transcripts.

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

SOCIAL SECURITY # \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

This section to be completed by the Dean, Registrar, or Chairperson of the Massage Therapy program at the United States school which the applicant COMPLETED. DO NOT complete this form in anticipation of program completion.

I hereby certify that:

1) \_\_\_\_\_ (Name of Applicant) successfully completed a Massage Therapy education program at \_\_\_\_\_ (School name) on \_\_\_\_\_ (Date).

2) The curriculum completed by Applicant equals or exceeds the curriculum requirements set forth in 49 Pa. Code § 20.11. Hours completed \_\_\_\_\_

Provide the number of hours for each area:

At least 175 contact hours of instruction in anatomy & physiology, kinesiology & pathology, including training in the human immunodeficiency virus & related risks. \_\_\_\_\_

At least 250 contact hours in massage therapy & bodywork assessment, theory & practice including sanitation, safety, & hygiene. \_\_\_\_\_

At least 25 contact hours in professional ethics, and business & law related to a massage therapy business. \_\_\_\_\_

At least 150 contact hours in related courses appropriate to a massage therapy curriculum as set forth in Section 20.13 (related to required knowledge base), including cardiopulmonary resuscitation. \_\_\_\_\_

Name of applicant \_\_\_\_\_

3) The school is:

- A Pennsylvania Private Licensed School
- Operated within a regionally accredited College or University

\_\_\_\_\_  
(Name of College or University)

- Approved by the MT Board or Department of Education of \_\_\_\_\_  
(State)

\_\_\_\_\_  
(Printed name & Signature of Dean/Registrar/Chairperson of M. T. Program)

\_\_\_\_\_  
(Date)

SCHOOL  
SEAL

Name of Program \_\_\_\_\_

Name of Controlling Institution \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

**OUT-OF-STATE SCHOOLS - PLEASE ATTACH A COPY OF THE SCHOOL  
CERTIFICATION/ACCREDITATION FOR THE TIME FRAME  
THE STUDENT ATTENDED THE PROGRAM**

**SCHOOL SHALL RETURN AN ORIGINAL COMPLETED FORM DIRECTLY TO BOARD OFFICE IN AN OFFICIAL ENVELOPE AND ATTACH STUDENT TRANSCRIPTS. (DO NOT send a copy of this form or use envelope if provided by applicant) Make sure to complete the form in its entirety as to not delay the processing of the application. Official school envelopes must have the school return address printed on the envelope, we will not accept stamped return addresses or printed labels with a return address.**