



Oregon

Kate Brown, Governor

Board of Massage Therapists

728 Hawthorne Ave NE

Salem, OR 97301

Phone: (503) 365-8657

Fax: (503) 385-4465

www.oregon.gov/OBMT

Application for Licensure

Applicant #: _____
(For official use only)

SSN: _____

Birth Date: _____

Last Name: _____

First Name: _____

Middle Initial: _____

Other Names: _____

Public Email Address: _____

NOTICE: As part of your application for an initial or renewed occupational or professional license, certification, or registration issued by the Oregon Board of Massage Therapists, you are required to provide your Social Security Number. This is mandatory. The authority for this requirement is ORS 25.785, ORS 305.385, 42 USC § 405 (c)(2)(C)(i), and 42 USC § 666 (a)(13). Failure to provide your Social Security Number is a basis for refusal to issue or renew the license, certification, or registration you seek. This record of your Social Security Number will be used for child support and tax administration purposes (including identification) only, unless you authorize other uses of the number. Although a number other than your Social Security Number appears on the face of the licenses issued by the Oregon Board of Massage Therapists, your Social Security Number will remain on file with the Oregon Board of Massage Therapists.

Home Address:

(Must be physical address)

City: _____

State: _____

Zip: _____

Phone: _____

Cell: _____

Mailing Address:

City: _____

State: _____

Zip: _____

Work Address:

(Location where the majority of massage is performed)

City: _____

State: _____

Zip: _____

Work Phone: _____

Work Cell: _____

On occasion, the Board receives requests for a list of LMTs licensed in Oregon.

Do you want to be excluded from the public mailing list? (Check one) YES NO

(If you circle yes, you will still receive Board mailings.)

Voluntary Affirmative Action Information:

Ethnic Background and Gender (check only one)

Asian or Pacific Islander African American Hispanic

Native American or Alaskan Native Caucasian Other

Physical Description

Height	Weight	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Hair Color	Eye Color	

Attach a FRONT-VIEW photograph, no larger than **2" x 2"** in this box.

Photo must have been taken within the last 12 months (1 year).

Primary modalities you intend to practice (e.g.: Swedish, Reiki and Reflexology).

1. _____ 2. _____ 3. _____

(Attach additional modalities as necessary)

I hold a massage therapist license in other state(s) State: _____ License #: _____

I hold a license to practice in the following field(s): Occupation(s): _____ State: _____

Any FALSE STATEMENT knowingly made in this application is grounds for revocation or suspension of your license.

If in doubt, disclose and explain rather than conceal. If you answer 'no' to question 4 based upon an "expungement", order "setting aside" or "sealing" of a record of a conviction or conditional discharge (diversion) you must personally verify with the court directly involved that the expungement, setting aside or sealing actually has taken place. An erroneous belief that a conviction has been expunged, set aside or sealed, when in fact it has not, will be deemed a false statement.

Please read each question **completely**. You must answer each question "yes" or "no", whichever is true.

1.	Have you EVER been required to register as a sex offender?	
2.	Have you EVER been investigated, disciplined or denied licensure by this or any other governmental licensing agency?	
3.	Have you EVER surrendered any professional license in any State, territory or jurisdiction?	
4.	Have you EVER been arrested or convicted for: (a) any felony; (b) misdemeanor; or (c) any major traffic violation, such as: driving under the influence of intoxicants or drugs • STOP: Major traffic violations such as: Tickets for Driving under the influence of drugs or intoxicants (even if you received diversion or if the case was dropped or dismissed); MUST BE REPORTED!	
5.	Have you EVER abused or been treated for the abuse of alcohol, a controlled, or mind altering substance?	
6.	Have you EVER received any in-patient mental health care for a psychological, addiction, or chemical dependency issue that affected your ability to safely practice?	

If you answer "Yes" to any of the questions above you **MUST** attach a detailed written explanation of the circumstances leading to and the outcome of the situation **AND** include copies of all related official documentation, including but not limited to: police reports, court documents, final actions and/or order, treating physician documentation, etc.

This background check will be a National FBI fingerprint background check. In accordance with 28 CFR § 16.34: "If, after reviewing his/her identification record, the subject thereof believes that it is incorrect or incomplete in any respect and wishes changes, corrections or updating of the alleged deficiency, he/she should make application directly to the agency which contributed the questioned information. The subject of a record may also direct his/her challenge as to the accuracy or completeness of any entry on his/her record to the FBI, Criminal Justice Information Services (CJIS) Division, ATTN: SCU, Mod. D-2, 1000 Custer Hollow Road, Clarksburg, WV 26306. The FBI will then forward the challenge to the agency which submitted the data requesting that agency to verify or correct the challenged entry. Upon the receipt of an official communication directly from the agency which contributed the original information, the FBI CJIS Division will make any changes necessary in accordance with the information supplied by that agency."

By my signature below I hereby certify that the information submitted on or relating to this form is true and correct and grant the Board permission to check civil or criminal records to verify any statement made on this application. The Board may **revoke** any license upon evidence that the applicant knowingly made any false statements in the application for this license. I understand that providing incomplete or inaccurate information **WILL** result in a delay of my renewal and may result in disciplinary action by the Board.

Signature of the Applicant

Date

Application Check List (Please include the following)

- A copy of a valid government-issued picture ID, such as a driver's license, passport, or military ID
- A list of three references that do not reside with you, yet can be relatives
- Official transcripts in a sealed envelope
- A copy of a current CPR certification (front and back)
- Results from National Written Exam (MBLEX/NCBTMB/CESI) ***NOTE: ALL NATIONAL EXAM RESULTS MUST COME DIRECTLY FROM THE EXAM PROVIDER.**
- Fingerprints taken at a Fieldprint Site
- Appropriate Fees:
 - **\$100.00** Non-refundable Application Fee.
 - **\$100.00** for initial License over 12 months OR **\$50** for initial license under 12 months
 - **\$40.00** Fingerprint Processing Fee

*The Initial License Fee is based upon renewal date, which is based upon applicant birth month/year. Individuals born in odd numbered years will renew every odd numbered year, regardless of when their initial license was issued. Those born during an even year will renew every even year. Additionally, licensees must renew *before* the first day of their birth month. If an applicant's first renewal is less than 12 months from time of issuance, the Initial License Fee is \$50.00. If the applicant's first renewal is more than 12 months from date of issuance, the Initial License Fee is \$100.00. Use the formula below to calculate your amount due.

A LICENSE CANNOT BE ISSUED UNTIL ALL APPLICATION REQUIREMENTS ARE COMPLETE AND ALL FEES HAVE BEEN PAID.

PAYMENT INFORMATION

*****Please provide payment information below.*****

Amount Due: _____ Last Name #: _____ First Name: _____

Check:
(Make payable to OBMT)

Check #: _____

Amount: \$ _____

Please circle option: Visa / MasterCard

Card #: _____ Exp Date: _____

V-code: _____ (for Visa only, reverse side of card)

Authorized Amount to Charge: \$ _____

Billing Address of Card: Street #: _____ Zip Code: _____
(Example: Write 728 for 728 Hawthorne Ave NE. Do not write the entire address.)

Complete and Return to: OBMT 728 Hawthorne Ave NE, Salem, OR. 97301