# MD BOARD OF CHIROPRACTIC & MASSAGE THERAPY EXAMINERS

## REINSTATEMENT FOR RENEWAL APPLICATION FOR 2014-2016

Previous License/Registration No.
#_____

How do I find it? Go to www.mdmassage.org click Verification link in Online Services Box

**BOARD USE ONLY**

Date RECEIVED: _____
APPROVAL Initials / Date: _____ / _____
Reviewer/Date: _____ / _____
Entered Database: _____
Check/MO No.: _____

INVESTIGATOR'S Initials: _____/ Date: _____
Background: □ COMPLETE □ PENDING

### REINSTATEMENT FOR RENEWAL 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 *"Board of Chiropractic & Massage Therapy Examiners"* Mailed to: 4201 Patterson Avenue, Suite 301, Baltimore, MD 21215, Attn: Adrienne Congo, MS, Deputy Director
Note: cash, credit cards, and walk-in payments are not accepted.

- REINSTATEMENT Application Fees for (LMT) – $661.00 (Includes $225 renewal fee, $200 reinstatement fee, $200 late fee and mandatory assessment of $36 by the Maryland Health Care Commission which applies to all Maryland Health Care Practitioners.
- REINSTATEMENT Application Fees for (RMP) – $625.00 (Includes $225 renewal fee, $200 reinstatement fee, and $200 late 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 maintains 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.U.S. Military Service
Gender o Male o Female

APPLICANTS MUST COMPLETE ALL SECTIONS OF THIS APPLICATION. PRINT LEGIBLY OR TYPE.

A. LEGAL FULL NAME _____ IS THERE A NAME CHANGE SINCE LAST ACTIVE STATUS ? o YES o NO
(If your name has changed; DOWNLOAD ADDRESS/NAME CHANGE FORM AND SUBMIT WITH THIS APPLICATION ).

CURRENT MAILING ADDRESS:_____ _____ State: _____ Zip Code: _____

HOME NO: _____ CELL: _____ WORK NO: _____

B. E-MAIL ADDRESS: *(Please provide your current, valid e-mail address for better communication from the Board and CEU providers)* _____

C. 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)*

_____ 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. Listed below is my required Workers' Compensation Insurance information.

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

## D. 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. COMPLETE AND COMPREHENSIVE ANSWERS TO AVOID DELAY.

_____ 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 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?

## E. CONTINUING EDUCATION (*TOTAL REQUIRED* = 24) & 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 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 Reinstatement Application. Reinstatement forms submitted WITHOUT copies of valid CEU completion certificates and a copy of your active CPR certification or card (front/back); WILL NOT BE PROCESSED and may be returned to you.

## F.

Active LMT Fee: $286.00 (*Includes Health Care Commission Fee of $36.00)* _____

Active RMP Fee: $250.00 _____

Reinstatement Fee: $200.00 (*In addition to the renewal fee )* _____

Reinstatement Late Fee: $200.00 *(Non-renewed status within 24 months last License/Registration exp. date)* _____

Duplicate Fee: $ 40.00 X _____(*$20.00 during Biennial Renewal Period – Aug. 30th – Nov. 30th*) _____

Check(s) or money order(s) number(s): _____ TOTAL FEES: $ _____

*Did you remember to: Answer ALL questions, enclose payment, attach copies of CEU completion certificates (retain originals for your records and renewal within this 2 year period), attach a copy of current CPR card (front/back) attach document(s) WITH explanation letter (*if you answered "Yes" in section "D")*; then *sign* and *date* the bottom of this form?

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 (FIRST NAME, MIDDLE NAME, LAST NAME | APPLICANT SIGNATURE | LIC. / REG. No. | DATE |

**Professional Competency & Background Explanation**
*(For yes answers to Questions 1-7 of Section D)*

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

- o **I have provided written information regarding answer(s) "Yes" for Questions 1-7 in Section D.**
- o **I have provided documentation attached regarding answer(s) "Yes" for Questions 1-7 in Section D.**