

MARYLAND MASSAGE THERAPY LICENSE & REGISTRATION
RENEWAL PAPER APPLICATION FOR 2010 -2012



Lic/Reg Last Name: _____
 First Name: _____
 Middle Int: _____
 Lic./Reg. No.: _____
 Phone No. : _____

BOARD USE ONLY

Status (A): _____
 Reviewer/Date: _____ / _____
 CEU Reviewer/Date: _____ / _____
 Entered Database: _____
 Notice Sent: _____
 Check/MO No.: _____
 Check/MO No.: _____
 Other: _____
 Background: COMPLETE PENDING Initials _____

MAIL TO: Md. Board of Chiropractic &
 Massage Therapy Examiners
 4201 Patterson Avenue, Suite 301
 Baltimore, MD 21215-2299

Office Phone No. 410-764-4738

RENEWAL APPLICATION FEES:

***SHOULD YOU CHOOSE NOT TO RENEW FOR 2010 – 2012 RENEWAL CYCLE; PLEASE CHECK THE BOX , PROVIDE CURRENT ADDRESS, INDICATE \$50.00 IN THE FEE SECTION AND THEN SIGN ,DATE, THE BOTTOM OF THE LAST PAGE, AND RETURN TO THE BOARD. I WILL NOT BE RENEWING THIS BIENNIAL AND TO KEEP MY STATUS AS A NON PRACTICING LMT/RMP IS ELECTING TO BECOME AN INACTIVE LMT/RMP.**

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 the **“Board of Chiropractic & Massage Therapy Examiners.”** NOTE: CASH, CREDIT CARDS, AND WALK-IN PAYMENTS **ARE NOT ACCEPTED.**

- ◆ **RENEWAL Application Fees for (LMT) – \$276.00** (Includes \$250.00 biennial renewal fee, and mandatory biennial assessment of \$26.00 by the Maryland Health Care Commission which applies to all Maryland Health Care Practitioners.)
- ◆ **RENEWAL Application Fees for (RMP) – \$250.00** (IS the biennial renewal fee.)
- ◆ **INACTIVE FEE for LMT and RMP - \$50.00** (The License or Registration holder on inactive status may reactivate their license registration at any time if the license or registration holder pays the reactivation fees as specified in COMAR 10.43.06.)

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

A. CURRENT MAILING ADDRESS:

* _____ Home Ph. No.: _____ Cell: _____

PREVIOUS ADDRESS: _____

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

B. 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:

_____ 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: _____

C. 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.**

- _____ 1. **Since your last active status**, have you been addicted to, or are 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 been **arrested** or pled *guilty, nolo contendere, no contest*, or been *convicted* or received *probation before judgment (PBJ)* 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 health care 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?

D. CONTINUING EDUCATION (TOTAL 24) & CPR CERTIFICATION:

You must submit copies of your CEU certificates and a copy of your current valid qualification in CPR along with this renewal form. **Renewal forms submitted without copies of CEU completion certificates and copies of CPR cards will be returned.** If exempt from the CEU requirements simply submit your exemption letter and a copy of your CPR card.

E. RENEWAL FEE CHECK-OFF:

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

Active RMP Fee: \$250.00 _____

Duplicate Fee: \$ 20.00 X _____ = _____

Inactive Fee: \$ 50.00 _____

Late Fee: \$200.00 *(In addition to the Active or Inactive Fee – pay on or after 11/1/2010)* _____

Reinstatement Fee: \$200.00 *(In addition to the Renewal and Late Fee – pay on or after 12/1/2010)* _____

Reactivation Fee: \$100.00 *(In addition to the renewal fee when changing from inactive to active status)* _____

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

Ⓜ Did you remember to: Enclose payment, answer all questions, attach copies of CEU completion certificates/CPR card, and

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 YOUR LEGAL FULL NAME & REQUESTED INFORMATION)

FIRST FULL MIDDLE LAST FULL SIGNATURE LIC / REG. No. DATE