COMMONWEALTH OF VIRGINIA
Department of Health Professions - Board of Nursing
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FOR OFFICE USE ONLY			
Fee Amount	Code	Approved	Date of Reinstatement

APPLICATION FOR REINSTATEMENT OF LICENSURE AS A MASSAGE THERAPIST

I hereby make application to reinstate my license as a **Massage Therapist** in the Commonwealth of Virginia. The following information in support of my application is submitted with a **check or money order** made payable to the *Treasurer of Virginia* **in the amount of $150. The fees are non-refundable.**

Disclosure of Addresses

Some licensees have expressed concern that their residence address is accessible. Consistent with Virginia law and the mission of the Department of Health Professions addresses of licensees are made available to the public. This has been the policy and the practice of the Commonwealth for many years. However, the application of new technology makes such information more accessible.

In most cases it is permissible for an individual to provide an address of record other than a residence, such as a Post Office Box or a practice location. Changes of address may be made at the time of renewal or at anytime by written notification to the appropriate health regulatory board. Please be advised that all notices from the board, to include renewal notices, licenses, and other legal documents, will be mailed to the address provided.

APPLICANT - Please provide the information requested below and on the back of this page. (Print or Type)		
Name: Last Suffix First Middle Maiden		
Street Address		Area Code & Telephone Number
City	State	Zip Code
Date of Birth (M/D/Y)	Social Security Number or Virginia DMV Control Number*	Virginia License Number LMT #0019- _____
School of Massage Therapy	Location	Date of Graduation
Date First Certificate/License Issued	Name at Time of Original Certification/Licensure Last First Middle Maiden	
If proof of name change to current name has not been filed with this office, submit a copy of marriage certificate or court order authorizing the change.		

Reinstatement due to lapse of certificate _____ or suspension or revocation of certificate _____

*** In accordance with §54.1-116 of the *Code of Virginia,* you are required to submit your Social Security Number or your Control Number issued by the *Virginia* Department of Motor Vehicles. If you fail to do so, the processing of your application will be suspended and fees will not be refunded.**
This number will be used by the Department of Health Professions for identification and will not be disclosed for other purposes except as provided for by law. Federal and state law requires that this number be shared with other agencies for child support enforcement activities.

1. This question applies to any license or certificate as a health care provider that may have been issued to you. Please answer **YES** or **NO** to *EACH* of the following: ***(If you answer yes to any of the questions, please explain in detail below and have certified copies of any applicable orders sent directly to this office.)***

- Has any license or certificate issued to you ever been voluntarily surrendered? YES _____ NO _____
- Have you ever had any of the following disciplinary actions taken against your license or certificate by any licensing authority in any jurisdiction: placed on probation, suspended, revoked or otherwise disciplined? YES _____ NO _____
- Has your practice ever been the subject of an investigation by any licensing authority? YES _____ NO _____
- Have you ever been denied a license or certification in a health-related field or jurisdiction? YES ____ NO ____

2. Is your license or certificate in good standing in all jurisdictions where licensed or certified? YES _____ NO _____

3. Have you completed the continuing competency requirements for the period in which the certificate has been lapsed, not to exceed four years, as required in 18 VAC 90-50-75 and 18 VAC 90-50-80? YES _____ NO _____
Please submit copies of all related documents with your application.

4. Please respond in full to the following questions. *You will need to provide documentation only if the response is different from that on your last application with this office.* Please answer **YES** or **NO** to each question.

- Have you ever been convicted, pled guilty to or pled Nolo Contendere to the violation of any federal, state or other statute or ordinance constituting a felony or misdemeanor? (Including convictions for driving under the influence, but excluding traffic violations)? Yes _____ No _____. **If yes, explain below** and have a **certified copy** of the court order sent directly to the Board of Nursing.
- Do you have a mental, physical or chemical dependency condition which could interfere with your current ability to practice massage? Yes _____ No _____. **If yes, explain below** and have a letter from your treating licensed professional summarizing diagnosis, treatment and prognosis sent directly to the Board of Nursing.

EXPLANATIONS:

AFFIDAVIT
(To be completed before a Notary Public)

State of _____ County/City of _____

Name _____, being duly sworn, says that he/she is the person who is referred to in the foregoing application for licensure as a massage therapist in the Commonwealth of Virginia; that the statements herein contained are true in every respect; that he/she has complied with all requirements of the law; and that he/she has read and understands the affidavit.

_____
Signature of Applicant

Subscribed to and sworn to before me this _____ day of _____, _____.

My commission expires on _____.

_____
SEAL Signature of Notary Public

Revised 07/01/16