COMMONWEALTH OF VIRGINIA
Department of Health Professions - Board of Nursing
Perimeter Center
9960 Mayland Drive, Suite 300
Henrico, VA 23233-1463

(804) 367-4515 – PHONE (804) 527-4455 – FAX
web: www.dhp.virginia.gov email: nursebd@dhp.virginia.gov

MASSAGE THERAPIST
CERTIFICATION/LICENSURE VERIFICATION FORM

TO THE APPLICANT: Complete the top portion **only** and send to the licensing authority in the state(s) where you were certified or licensed as a massage therapist (**fee may be required**).

Name – Last First Middle	Social Security Number or Virginia DMV Control Number

Address

License or certification number:	Year Issued:

Name on Original License:

TO THE LICENSING AUTHORITY: Please provide information requested and mail form directly to the Virginia Board of Nursing.

APPLICANT'S FULL NAME:
Last First Middle Maiden

Was school approved/accredited at time applicant graduated?	Date Program Completed:	Was program 500hrs or more:
YES ☐ NO ☐		YES ☐ NO ☐

Name of School _____

Location: _____

Title of Examinations Taken: ☐ NCETMB _____/_____/_____ ☐ NCETM _____/_____/_____
Date Examination Passed Date Examination Passed

☐ MBLEX _____/_____/_____ ☐ OTHER _____ _____/_____/_____
Date Examination Passed Date Examination Passed

Name of Organization that Administered Exam: ☐ NCBTMB ☐ FSMTB ☐ OTHER _____

License/Certificate Number _____was granted on _____/_____/_____ expires _____/_____/_____

Obtained By: ☐examination ☐endorsement ☐waiver ☐ other _____

Status of license/certification: ☐Current ☐Lapsed ☐Inactive ☐other _____

Has license/certificate ever been denied, suspended, revoked, placed on probation or otherwise disciplined?
YES ☐ NO ☐ ***If yes, please attach certified copy of order issued by the certifying/licensing body.***

I certify the above information to be true in every respect, according to the record on file with the _____
_____Licensing/Certifying Authority.

_____ _____
Date **Executive Director**

SEAL

REVISED 4/18/14