



Massage Practitioner License Application Packet

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Important Social Security Number Information:

You are required by state and federal law to provide a social security number with your application. If you do not have a social security number at the time you send in this application, please read, complete, and return this [form](#) with your application.

A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted.

In order to process your request:

Mail your application with initial documentation and your check or money order payable to:

Department of Health
P.O. Box 1099
Olympia, WA 98507-1099

Send other documents not sent with initial application to:

Board of Massage Credentialing
P.O. Box 47877
Olympia, WA 98504-7877

Contact us:

360-236-4700

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Application Instructions Checklist

Important background check Information: Washington State law authorizes the Department of Health to obtain fingerprint-based background checks for licensing purposes. This check may be through the Washington State Patrol and the Federal Bureau of Investigation (FBI). This may be required if you have lived in another state or if you have a criminal record in Washington State. This would be at your own expense.

All information should be printed clearly in blue or black ink. It is your responsibility to submit the correct required forms.

Application Fee. This fee is **non-refundable**. You can check the online [fee page](#) for current fees.

Select One: Transfer, approved jurisdiction or examination

Select if the following applies:
Spouse or Registered Domestic Partner of Military Personnel

1. Demographic Information:

Social Security Number: You must list your social security number on your application. Please call the Customer Service Center at 360-236-4700 if you do not have one.

National Provider Identifier Number (NPI): The National Provider Identifier (NPI) is a standard unique identifier for health care professionals available from the Federal Centers for Medicare and Medicaid Services. The NPI is a 10 digit numeric identifier. If you have a NPI number, provide this on your application.

Legal Name: List your full name: first, middle, and last.

Definition of legal name: "Legal name" is the name appearing on your official certificate of birth or, if your name has changed since birth, on an official marriage certificate or an order by a court. The court must have the legal authority to change your name. We may ask you to prove your legal name. If you use any name other than your legal name on this form, your application may be denied.

Birth date: Provide the month, day, and year of your birth.

Birth place: Provide the city, state and country where you were born.

Address: List the address we should use to send any information about your license. Be sure to include the city, state, zip code, county, and country. This will be your permanent address with Department of Health until we have been notified of a change. See [WAC 246-12-310](#).

Phone, Fax and Cell Numbers: Enter your phone, fax and cell numbers, if you have them.

Email: Enter your email address, if you have one.

Other Name(s): Indicate whether you are known or have been known under any other names. If you have a name change, you must notify the Department of Health in writing. You must include proof of this change. See [WAC 246-12-300](#).

2. Personal Data Questions:

All applicants must answer the same personal data questions. They are focused on your fitness to practice the essential skills of this profession.

If you answer “yes” to any questions in this section, you must provide an appropriate explanation. You must also provide the documentation listed in the note after the question. If you do not provide this, your application is incomplete and it will not be considered.

- Question 5 includes misdemeanors, gross misdemeanors and felonies. You do not have to answer yes if you have been cited for traffic infractions. You can get copies of court records through the county courthouse where the conviction, plea, deferred sentence, or suspended sentence was entered.
- Another jurisdiction means any other country, state, federal territory, or military authority.

3. Other License, Certification or Registration:

List all states where licenses are or were held. Specifically list licenses granted as temporary, reciprocity, exemption or similar with type, date, grantor, and if license is current. Attach additional completed pages if you need more space.

4. Professional Education:

List in date order, most recent to later, your educational preparation and post-graduate training. Attach additional completed pages if you need more space.

5. Professional Experience:

List in date order, most recent to later, all professional experience and practice from date of graduation from professional college. Attach additional pages if you need more space.

6. Examination Data:

If you have taken the FSMTB or the NCBTMB examination, you are considered to have met the examination requirement. You must get written verification for the examination taken, sent directly to the department.

7. AIDS Education and Training Attestation:

Read the AIDS education and training attestation. AIDS training may include self-study, direct patient care, courses, or formal training. A minimum of four hours is required. You can find course content in [WAC 246-12-270](#). If AIDS education was included in your professional education or training, an additional course is not required.

8. Applicant’s Attestation:

You must sign and date this for us to process the application.

Additional Information:

Criminal history checks are conducted for all massage license applicants. If you answered yes to any of the personal data questions, please submit the appropriate supporting documentation as indicated on the application.

- The initial license will expire on your birthday unless the license is issued within 90 days of your next birthday. See [WAC 246-12-020\(3\)](#).
- You will receive a courtesy renewal notice if your license and address are kept up to date. Any renewal postmarked or given to the department after midnight on the expiration date is late.

Note: You cannot practice massage until your license is issued.

For Spouses and Registered Domestic Partners of Military Personnel Being Transferred or Stationed in Washington:

Under state law, if you are the spouse or state-registered domestic partner of a servicemember of any branch of the U.S. Military, to include Guard or Reserve, and are applying for a health care professional credential in this state, you may be eligible to have the processing of your application expedited to receive your credential more quickly.

Documents to submit with your application should include the following:

- A copy of your spouse's or registered domestic partner's military transfer orders to Washington State.
- One of the following:
 - A copy of your marriage certificate to show proof of marriage; or
 - A copy of a state's declaration or registration showing you are in a state registered domestic partnership with a member of the U.S. military.

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License Requirements

Thank you for applying to become a licensed massage practitioner in Washington State.

All applicants must submit the following:

- Completed application and [fee](#)
- Complete the [Washington State Jurisprudence Examination](#)
- Verification of all credentials that you hold or have previously held.
 - You will need to submit a request for verification to all U.S. and foreign boards and jurisdictions where you have held a professional license.
Note: We will not accept a copy of your license.
- Official examination score report from the National Certification Board for Therapeutic Massage and Body Work (NCBTMB) or Federation of State Massage Therapy Boards (FSMTB) must be submitted directly to the Department of Health.
- CPR and First Aid Card
 - Submit a photocopy, front and back, of your current Red Cross/First Aid Card and American Heart Association CPR card (or equivalent showing the expiration dates)

If you are applying for a license by examination you must also submit:

- If you completed a [Washington State Board Approved Program](#) submit an original [school completion form](#).
 - The form needs to be stamped and signed by the registrar or authorized representative of a board-approved massage or apprenticeship program. At the time of graduation, the hours and length of the program must also match the board approved program.

Or;

- If you did not complete a Washington State Board Approved Program but have completed an out-of-state program that was a minimum of 500 hours and six months in length, your educational program must submit official transcripts and complete an original [Education Endorsement Form](#).
 - The completed massage program must be approved by the state board and licensing agency or accrediting agency at the time of completion. Transcripts must be submitted in an official sealed envelope in addition to this form.

Note: If you have completed or attended an out-of-state program that is less than six months or under 500 hours you may apply by transfer program.

If you are applying for a license by transfer program you must also submit:

- Official transcripts sent directly from your unapproved program.
- Request that your approved school submit documentation directly to the Department of Health showing how the non-approved school meets the transfer education standards.
- Complete an original [school completion form](#).
 - The form needs to be stamped and signed by the registrar or authorized representative of a board-approved massage or apprenticeship program where you completed your transfer.

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Date
Stamp
Here

Revenue 024201000

Massage Practitioner License Application

Please print clearly. It is the responsibility of the applicant to submit all required supporting documentation. Follow all instructions provided. Failure to do so may result in a delay in processing your application.

Please select one of the following:

Examination Transfer

Select if the following applies: Spouse or Registered Domestic Partner of Military Personnel

1. Demographic Information

Social Security Number (SSN) (If you do not have a SSN, see instructions)	National Provider Identifier Number (NPI) (Enter 10 digit number)	<input type="checkbox"/> Male <input type="checkbox"/> Female
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Name	First	Middle	Last
------	-------	--------	------

Birth date (mm/dd/yyyy)	Place of birth		
	City	State	Country

Address

City	State	Zip Code	County
------	-------	----------	--------

Country

Phone (enter 10 digit #)	Fax (enter 10 digit #)	Cell (enter 10 digit #)
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Email address

Mailing address if different from above address of record

City	State	Zip Code	County
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Country

Note: The mailing and email addresses you provide will be your addresses of record. It is your responsibility to maintain current contact information on file with the department.

Have you ever been known under any other name(s)? Yes No

If yes, list name(s):

Will documents be received in another name? Yes No

If yes, list name(s):

2. Personal Data Questions

Yes No

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please attach explanation.....

“Medical Condition” includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, intellectual disabilities, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

If you answered yes to question 1, explain:

- 1a. How your treatment has reduced or eliminated the limitations caused by your medical condition.
1b. How your field of practice, the setting or manner of practice has reduced or eliminated the limitations caused by your medical condition.

Note: If you answered “yes” to question 1, the licensing authority will assess the nature, severity, and the duration of the risks associated with the ongoing medical condition and the ongoing treatment to determine whether your license should be restricted, conditions imposed, or no license issued.

The licensing authority may require you to undergo one or more mental, physical or psychological examination(s). This would be at your own expense. By submitting this application, you give consent to such an examination(s). You also agree the examination report(s) may be provided to the licensing authority. You waive all claims based on confidentiality or privileged communication. If you do not submit to a required examination(s) or provide the report(s) to the licensing authority, your application may be denied.

2. Do you currently use chemical substance(s) in any way which impair or limit your ability to practice your profession with reasonable skill and safety? If yes, please explain.....

“Currently” means within the past two years.

“Chemical substances” include alcohol, drugs, or medications, whether taken legally or illegally.

3. Have you ever been diagnosed with, or treated for, pedophilia, exhibitionism, voyeurism or frotteurism?.....

4. Are you currently engaged in the illegal use of controlled substances?.....

“Currently” means within the past two years.

Illegal use of controlled substances is the use of controlled substances (e.g., heroin, cocaine) not obtained legally or taken according to the directions of a licensed health care practitioner.

Note: If you answer “yes” to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The department does criminal background checks on all applicants.

5. Have you **ever** been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferred or suspended as an adult or juvenile in any state or jurisdiction? ...

Note: If you answered “yes” to question 5, you must send certified copies of all court documents related to your criminal history with your application. If you do not provide the documents, your application is incomplete and will not be considered.

To protect the public, the department considers criminal history. A criminal history may not automatically bar you from obtaining a credential. However, failure to report criminal history may result in extra cost to you and the application may be delayed or denied.

2. Personal Data Questions (cont.)

Yes No

6. Have you ever been found in any civil, administrative or criminal proceeding to have:
- a. Possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes?
 - b. Diverted controlled substances or legend drugs?
 - c. Violated any drug law?
 - d. Prescribed controlled substances for yourself?
7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", please attach an explanation and provide copies of all judgments, decisions, and agreements?
8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority?
9. Have you ever surrendered a credential like those listed in number 8, in connection with or to avoid action by a state, federal, or foreign authority?
10. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence, or malpractice in connection with the practice of a health care profession?
11. Have you ever been disqualified from working with vulnerable persons by the Department of Social and Health Services (DSHS)?

3. Other License, Certification, or Registration

List all states including Washington where licenses/certifications/registrations are or were held.

State	License/certification/registration type	License/certification/registration		Method of license		
		Year Issued	Number	Exam	Endorse	Grand fathered

4. Professional Education

List in date order, most recent to later all your educational preparation and post-graduate training. Attach additional pages if you need more space.

Schools Attended Full Name, City and State	Degree Earned	Attendance	
		From (mm/dd/yyyy)	To (mm/dd/yyyy)

5. Experience

List in date order all professional experience and practice from date of graduation from professional college. Include the month/day/year. Attach additional pages if you need more space.

Type of experience and location	Start Date (mm/dd/yyyy)	End Date (mm/dd/yyyy)

6. Examination Data

Have you taken and passed the FSMTB or the NCBTMB exam?

NCBTMB Yes No If yes, date taken _____

FSMTB Yes No If yes, date taken _____

Official verification in the form of official scores must be sent directly from the NCBTMB or the FSMTB to the Department of Health.

7. AIDS Education and Training Attestation

I certify I have completed the minimum of four hours of education in the prevention, transmission and treatment of AIDS. This includes the topics of etiology and epidemiology, testing and counseling, infection control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and psychosocial issues to include special population considerations.

I understand I must maintain records documenting said education for two years and be prepared to submit those records to the department if requested. **I understand should I provide any false information, my license may be denied, or if issued, suspended or revoked.** If AIDS education was included in your professional education or training, an additional course is not required.

Applicant's Initials	Date

8. Applicant's Attestation

I, _____, declare under penalty of perjury under the laws of
(Print applicant name clearly)
the state of Washington the following is true and correct:

- I am the person described and identified in this application.
- I have read [RCW 18.130.170](#) and [RCW 18.130.180](#) of the Uniform Disciplinary Act.
- I have answered all questions truthfully and completely.
- The documentation provided in support of my application is accurate to the best of my knowledge.
- I have read all laws and rules related to my profession.

I understand the Department of Health may require more information before deciding on my application. The department may independently check conviction records with state or federal databases.

I authorize the release of any files or records the department requires to process this application. This includes information from all hospitals, educational or other organizations, my references, and past and present employers and business and professional associates. It also includes information from federal, state, local or foreign government agencies.

I understand I must inform the department of any past, current or future criminal charges or convictions. I will also inform the department of any physical or mental conditions that jeopardize my ability to provide quality health care. If requested, I will authorize my health providers to release to the department information on my health, including mental health and any substance abuse treatment.

Dated _____ By: _____
(mm/dd/yyyy) (Signature of applicant)

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Board of Massage Credentialing
P.O. Box 47877
Olympia, WA 98504-7877
360-236-4700

Out-of-State Credential Verification

To Applicant:

Please complete this side of form and send it to the state(s) and/or jurisdiction(s) where you are or have been licensed, certified, or registered as a healthcare provider. Instruct them to return the form directly to the address listed above. Make a copy of this form if you need to send it to more than one state or jurisdiction. Agencies normally charge a fee for verification. Please check in advance to help expedite this process.

Name: Last			First			Middle		
Mailing Address								
City						State		Zip Code
Any other names used:								
Type of healthcare license, certification, or registration:								
License, Certification, or Registration Number						Date Issued		

Have the licensing agency return this completed form to the address listed above.

If you have any questions, please call 360-236-4700.

(To be Completed by the Regulatory Agency)

Please complete this form regarding the applicant listed on the reverse. Submit the completed form and any other requested material directly to this office at the address on the reverse. We will not accept the form if submitted by the applicant. Thank you.

Name of license, certification, or registration holder:		
Authority providing verification: (state, name & title)		
Applicant was credentialed by:	Date:	Score:
<input type="checkbox"/> Written Examination		
Name of examination:		
<input type="checkbox"/> Other Examination	Date:	Score:
Name of examination:		
Is credential current: <input type="checkbox"/> Yes <input type="checkbox"/> No	Expiration Date:	
Is this individual considered to be in good standing in your state? <input type="checkbox"/> Yes <input type="checkbox"/> No If "no," please attach explanation.		
Has this credential ever been denied?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Suspended?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Revoked?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Surrendered?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Reinstated?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
If "yes," please provide a copy of the final order or other documentation of action taken.		
If this credential holder has been disciplined, has he/she successfully completed all requirements and is currently in good standing? <input type="checkbox"/> Yes <input type="checkbox"/> No		

(SEAL)

Signature:

Title:

Date:



Washington State Department of
Health
 Board of Massage Credentialing
 P.O. Box 47877
 Olympia, WA 98504-7877
 360-236-4700

Board of Massage Education Endorsement Form

Only Education Endorsement forms sent directly from the school will be accepted.

This form must be completed for applicants that are applying for a massage license and have complete an out-of-state course that was at least 500 hours and six months in length. The completed massage program must be approved by the state board and licensing agency or accrediting agency at the time of graduation. Transcripts should submitted in an official sealed envelope in addition to this form.

Applicant Information:

Applicant Name _____

School or Program Information:

Name of the school or program the applicant graduated from		State of school or program
Program Entry Date	Program Completed Date	Total Program Hours

State Board and Licensing Agency or the Accrediting Agency Information:

Was the school approved by the state’s massage board at the applicant’s time of graduation?

Yes, List the full name of the state board _____

No N/A If no or N/A, select which of the following the school was approved by:

A national or regional accreditation organization

 Name

The state authority with responsibility for oversight of vocational programs

 Name

The state agency that regulates massage programs

 Name

Other—List:

 Name

As an authorized representative of the school listed above, I attest that the applicant has successfully completed the school’s massage program and that the school was approved by the state board and/ required accrediting or licensing agency at the applicant’s time of graduation.

 Printed name of school registrar or authorized representative

 Signature

 Date

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Washington State Department of
Health
 Board of Massage Credentialing
 P.O. Box 47877
 Olympia, WA 98504-7877
 360-236-4700

Board of Massage School Completion Form

Only Massage School Completion Forms sent directly from the school will be accepted.

Please print clearly. Only School Completion forms sent directly from the board-approved school will be accepted. If your school offers more than one massage program **or** if there is more than one campus, then each individual campus and/or program must be approved by the Board of Massage. The school program and/or campus must be approved prior to the applicant's graduate date. If an applicant did not graduate from a Washington State Board approved campus and/or program, then the applicant is not eligible for a license.

Applicant Name _____ Did applicant transfer hours? Yes (See Page 2)
 No

Board approved school and program that the applicant graduated from _____

Program Entry Date _____ Program Completed Date _____ Hours Completed _____
 (Only report hours earned at board approved school)

As the above-mentioned school registrar or authorized representative, I attest that the above name applicant has successfully completed the training listed in [WAC 246-830-430](#) to be a licensed massage practitioner in Washington State.

Place Washington State Board Approved School Stamp below (form is not valid without number stamp). 

Printed name of school registrar or authorized representative _____

Signature _____ Date _____



If the applicant has transferred hours, complete page two.

This section only needs to be completed if applicant completed a transfer program.

Board Approved Transfer School

Program Entry Date

Program Completion Date

Hours completed in the above referenced program

One hundred thirty hours of Anatomy, Physiology, and Kinesiology including palpation, range of motion, and physics of joint function. There must be a minimum of forty hours of Kinesiology.

Hours completed at board approved school (including Kinesiology hours)

Hours completed at transfer school

Hours completed in Kinesiology

Fifty hours of pathology including indications and contraindications consistent with the particular area of practice.

Hours completed at board approved school

Hours completed at transfer school

Two hundred sixty-five hours of theory and practice of massage to include techniques, remedial movements, body mechanics of the practitioner, and the impact of techniques on pathologies. A maximum of fifty of these hours may include time spent in a student clinic. Hydrotherapy shall be included when consistent with the particular area of practice.

Hours completed at board approved school

Hours completed at transfer school

Time spent in a student clinic

Fifty-five hours of clinical/business practices at a minimum to include hygiene, record keeping, medical terminology, professional ethics, business management, human behavior, client interaction, and state and local laws.

Hours completed at board approved school

Hours completed at transfer school

RCW/WAC and Online Website Links

RCW/WAC Links

[Uniform Disciplinary Act, RCW 18.130](#)

[Administrative Procedure Act, RCW 34.05](#)

[Administrative Procedures and Requirements, WAC 246-12](#)

On-Line

[Board of Massage, Web Page](#)

[National Certification Board, \[www.ncbtmb.com\]\(http://www.ncbtmb.com\)](#)

[AIDS Training Resource, Reference Page](#)

[Federation of State Massage Therapy Boards, \[www.fsmtb.org\]\(http://www.fsmtb.org\)](#)

[Washington State Approved Massage Programs, School List](#)

[Jurisprudence Exam](#)