

### **Application for Post-Secondary Massage Therapy School**

**A.** Any person, firm or corporation seeking to open a Post-Secondary school of Massage Therapy shall submit an application with required forms to the Massage Therapy Section office and receive pre-approval from the Department.

The application shall include:

**1.** Completed application provided by the Department and available on the Department's website.

**2.** Describe the location of your school, type of structure, and furnish a detailed floor plan in compliance with Section 9 Rule 4.

**3.** List of proposed equipment used for instructional purposes in compliance with Section 9 Rule 4.

**4.** Submit proposed curriculum including name and addition of textbooks and any other material that will be used for instructional purposes.

**5.** List of instructors and their qualifications.

**6.** Submit samples of all forms to be used in the school, such as, contract, sign-in sheets, attendance records, transcripts, guest instructor log, etc.

**7.** Submit a copy of your school's handbook- including refund policy. Postsecondary Schools must also include a disciplinary policy.

**8.** Valid background checks for each owner.

**9.** Application Fee

**B.** A person shall not establish, operate, or maintain a massage therapy school without first having obtained a certificate of massage therapy school licensure issued by the Department.

**C.** Any Massage Therapy School wishing to teach both secondary and postsecondary students shall obtain both a license for a Massage Therapy School and a Postsecondary Massage Therapy School. The school shall also provide a procedure by which it will ensure that only students with a high school diploma or the equivalent are enrolled in the postsecondary school and receive Title IV funds.

**D.** After satisfactory completion of initial requirements, schools are required to undergo Department inspection before they can be licensed.

**a.** A Department staff member will perform an inspection of the school premises with required forms completed, and the results of such inspection will be returned to the Department for approval and/or adjustment recommendations.

**b.** Facilities that do not pass the first inspection will be re-inspected within thirty (30) days of notification of corrections.

**E.** Post-secondary Massage Therapy Schools must show proof that the school adopts and discloses to the students a complaint process substantially similar to the one outlined in Section Four of these Rules.

Arkansas Department of Health  
 Massage Therapy Section  
 4815 West Markham, Slot 8  
 Little Rock, AR 72205  
 (501) 683-1448

**POST-SECONDARY SCHOOL OF MASSAGE APPLICATION**

**Registration Fees:**

New school registration fee: \$850.00  
Satellite School registration fee: \$425.00

**SCHOOL INFORMATION**

<b>SCHOOL</b>			<b>TELEPHONE NUMBER</b>	
<b>MAILING ADDRESS</b>	<b>CITY</b>	<b>COUNTY</b>	<b>STATE</b>	<b>ZIP CODE</b>
<b>PHYSICAL ADDRESS</b>	<b>CITY</b>	<b>COUNTY</b>	<b>STATE</b>	<b>ZIP CODE</b>
<b>EMAIL ADDRESS (REQUIRED)</b>	Days Closed <input type="checkbox"/> SUNDAY <input type="checkbox"/> MONDAY <input type="checkbox"/> TUESDAY <input type="checkbox"/> WEDNESDAY <input type="checkbox"/> THURSDAY <input type="checkbox"/> FRIDAY <input type="checkbox"/> SATURDAY			

**OWNER INFORMATION - If Sole Proprietorship or Partnership list the name, mailing address, and phone number for the owner(s).**

<b>OWNERSHIP INFORMATION</b> (CIRCLE ONE)	<input type="checkbox"/> <b>SOLE PROPRIETORSHIP</b> <input type="checkbox"/> <b>PARTNERSHIP</b> <input type="checkbox"/> <b>CORPORATION</b>			
<b>SOLE PROPRIETORSHIP OR PARTNERSHIP</b>			<b>TELEPHONE NUMBER</b>	
<b>MAILING ADDRESS</b>	<b>CITY</b>	<b>COUNTY</b>	<b>STATE</b>	<b>ZIP CODE</b>
<b>SOLE PROPRIETORSHIP OR PARTNERSHIP</b>			<b>TELEPHONE NUMBER</b>	
<b>MAILING ADDRESS</b>	<b>CITY</b>	<b>COUNTY</b>	<b>STATE</b>	<b>ZIP CODE</b>

**CORPORATION INFORMATION - If a corporation, list the exact name of the Corporation, names, mailing address and phone number of the President, Secretary, and Agent of Service of the Corporation.**

<b>NAME OF CORPORATION</b>	<b>TELEPHONE NUMBER</b>			
<b>MAILING ADDRESS</b>	<b>CITY</b>	<b>COUNTY</b>	<b>STATE</b>	<b>ZIP CODE</b>
<b>PRESIDENT'S NAME and ADDRESS</b>			<b>TELEPHONE NUMBER</b>	
<b>SECRETARY'S NAME and ADDRESS</b>			<b>TELEPHONE NUMBER</b>	
<b>AGENT OF SERVICE NAME and ADDRESS</b>			<b>TELEPHONE NUMBER</b>	

<b>OWNER'S SIGNATURE</b>	<b>TODAY'S DATE</b>
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ARKANSAS DEPARTMENT OF HEALTH  
MASSAGE THERAPY SECTION  
**SCHOOL INSTRUCTOR FORM**

- 1) Every Massage Therapy school shall at all times be under the immediate supervision of a School Instructor.
- 2) A School Instructor must be currently licensed as a Massage Therapy instructor.

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**INSTRUCTOR'S NAME** \_\_\_\_\_ **Phone #** \_\_\_\_\_

**LICENSING RECORD:** LMT: \_\_\_\_\_ years, from \_\_\_\_\_ to \_\_\_\_\_ Lic ID# \_\_\_\_\_  
MO & YR MO & YR

Instructor: \_\_\_\_\_ years, from \_\_\_\_\_ to \_\_\_\_\_ Lic ID# \_\_\_\_\_  
MO & YR MO & YR

**EXPERIENCE RECORD:** (Experience that qualifies for Instructor Position)  
**MASSAGE THERAPIST EXPERIENCE** (Employment date state Months and Years)

\_\_\_\_\_  
Employer's Name Spa Name City State Phone # Emp Dates Beg/End

\_\_\_\_\_  
Employer's Name Spa Name City State Phone # Emp Dates Beg/End

\_\_\_\_\_  
Employer's Name Spa Name City State Phone # Emp Dates Beg/End

**INSTRUCTOR EXPERIENCE** (Employment date state Months and Years)

\_\_\_\_\_  
Employer's Name School Name City State Phone # Emp Dates Beg/End

\_\_\_\_\_  
Employer's Name School Name City State Phone # Emp Dates Beg/End

\_\_\_\_\_  
Employer's Name School Name City State Phone # Emp Dates Beg/End

**CERTIFICATION**

I, \_\_\_\_\_, do hereby certify that the employment record contained on this form is an accurate record of my employment history.

DATE: \_\_\_\_\_ INSTRUCTOR'S SIGNATURE \_\_\_\_\_

I, \_\_\_\_\_, d/b/a \_\_\_\_\_ do hereby certify that the above-named individual is under my employment in the capacity of INSTRUCTOR.

DATE: \_\_\_\_\_ OWNER'S SIGNATURE \_\_\_\_\_

**ARKANSAS DEPARTMENT OF HEALTH  
MASSAGE THERAPY SECTION  
AUTHORIZED DESIGNEE CERTIFICATION**

I, \_\_\_\_\_, d/b/a \_\_\_\_\_  
OWNER'S NAME SCHOOL NAME

do hereby designate and authorize \_\_\_\_\_ to accept service of notice  
DESIGNEE'S NAME  
from the Department and to transact all business negotiations on behalf of the school, including answers to citations for hearing, and compliance with rulings issued by the Department.

DATED THIS \_\_\_\_\_ DAY OF \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_  
OWNER/ADMINISTRATOR'S SIGNATURE

\_\_\_\_\_  
DESIGNEE'S SIGNATURE