ARKANSAS DEPARTMENT OF HEALTH
MASSAGE THERAPY SECTION
4815 West Markham, Slot 8
Little Rock, AR 72205
(501) 683-1448

SCHOOL CHANGE OF STATUS APPLICATION

INSTRUCTIONS: The purpose of this form is for any type of change of status to an existing school.

REQUIREMENTS TO CHANGE OWNER:

Purchase of an Existing Massage Therapy School or Massage Therapy Post-Secondary School
(A) Any person, firm or corporation seeking to purchase an existing school or Post-secondary shall submit the following information at least thirty (30) days prior to the purchase:
(1) An application shall be filed to reflect the change of ownership.
(3) Copy of the legal change of ownership document.
(4) Copy of the new owner's government issued photo identification.

SCHOOL INFORMATION CURRENTLY ON FILE WITH THE MASSAGE THERAPY SECTION (*PRIOR TO CHANGE*)

School Name			Telephone Number ( )		
Address Where School Receives Mail	Suite #	City	County	State	Zip Code
Physical Address of School	Suite #	City	County	State	Zip Code
Name of Owner (Corporation or Individual)			LICENSE NUMBER		

NEW SCHOOL OWNER

Is the NEW owner a corporation? YES NO	If yes, name of corporation		If no, is new owner licensed? YES NO		License number
Last Name	First Name (no nicknames)		Middle Name		SSN
Date of Birth	Gender (Circle One) MALE FEMALE	Race (circle one)	Black	White	Am. Indian	Hispanic	Asian	Alaskan Native
Address Where You Receive Mail	Apt #	City	County	State	Zip Code
Address Where You Live	Apt #	City	County	State	Zip Code
Phone ( )	**Email Address (REQUIRED)**				

SECTION (D) – OWNER CERTIFICATION

In signing this application, you are certifying that:
1. The information provided on this form is correct to the best of your knowledge.
2. You are the School owner or are authorized to act as the owner's agent.
3. You have read this form, the laws and rules.
4. You have complied with all laws and rules governing cosmological Schools.
5. You will close your School if the inspector finds the School not in compliance with applicable rules.

Print Owner's Name	Owner's Signature	Today's Date

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.

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