

**Arkansas Department of Health
 Massage Therapy Section
 4815 West Markham, Slot #8
 Little Rock, AR 72205
 Phone: (501) 683-1448
 Fax: (501) 682-5640**

**Continuing Education (CE) Provider Application and
 Request for Department of Health Course Approval/Code**

**NOTE: Attach a statement and copies of the Provider's qualifications that satisfy the requirements of
Arkansas, (i.e., copies of diplomas/degrees and specialized training and/or teaching verification).
 Include with application a \$40.00 Non-Refundable Application Fee**

CE Program Title

Type or Print Legibly

Title	Credit Hours
-------	--------------

CE Course Provider Information

Name	Title	Social Security Number	
Mailing Address	Suite/Apt	License Type	License Number
City	State	Zip	County
Home Phone	Work Phone or Alternate Phone		Email Address

Attendance/Recordkeeping Contact

Name	Phone
Mailing Address	Suite/Apt
City	State Zip County

Provider's Personal References (Do not include relatives)

Name	Occupation/Job Title	Years Known
Address	Suite/Apt	Home Phone
City	State Zip	Work Phone
Name	Occupation/Job Title	Years Known
Address	Suite/Apt	Home Phone
City	State Zip	Work Phone
Name	Occupation/Job Title	Years Known
Address	Suite/Apt	Home Phone
City	State Zip	Work Phone

Provider's Massage Related Education Background

School Name		Total Hours Completed	
Address		Suite/Apt	
City	State	Zip	County
Director's Name	Phone	Enrollment Date	Graduation Date

Provider's Specialized Massage Training/Education (attach additional sheets if necessary)

List all specialized training relevant to this proposed CE program including relevant CE classes, certification courses, and/or other related education training experiences. Attach photocopies of transcripts, diplomas, and certificates of completion for any coursework listed.

Provider's Experience (attach additional sheets if necessary)

List all work-related positions held that identify relevant work experience in the subject matter of the proposed CE program. Specify job titles and detailed descriptions of job duties that demonstrate experience. Include employment dates, hours worked, and other relevant employment information. Include any previous experience teaching the subject of this program. If appropriate, include a resume with the teaching experience.

CE Program's Subject Matter (attach additional sheets if necessary)

Provide a detailed outline of the course curriculum. Attach the proposed course syllabus, informational materials, detailed written procedural instructions including known contraindications, a listing of textual references or works cited, and any other informational and/or instructional handouts, brochures, pamphlets, illustrations, figures, charts, graphs, tables, etc. If a course workbook is provided to students, include the entire course workbook within the application packet. If using PowerPoint presentations, include a hardcopy of each slide. Include photocopies of any advertisements.

CE Program's Learning Objectives (attach additional sheets if necessary)

Describe the behavioral terms the students' attainable learning objectives that can be evaluated and are relevant to massage therapy.

CE Program's Teaching Methodologies (attach additional sheets if necessary)

List the teaching methodologies for instruction of adult learners in this proposed CE program, such as lecture, PowerPoint presentation, demonstration, hands-on training, etc.

NOTE: Out-of-State applicants applying to provide the Department approved CE Programs should also submit a photocopy of their current registrations and/or licenses, and include photocopies of their official transcript(s) and diploma(s) from their primary massage therapy institution/school.

Affidavit of Applicant with Acknowledgment
(Notarization required)

Applicant

I declare and affirm that the statements made in this application, and any accompanying documents, are true, complete and correct. I understand that any false or misleading information in, or in connection with, my application may be cause for denial or loss of approval and may result in criminal prosecution. I agree to abide by the requirements set forth in the laws, rules and regulations established by the Department.

Signature License #: _____

Date

Notary

State of _____

County of _____

Signed and sworn to before me this _____ day of _____, 20_____

by _____, who personally appeared before me.

Notary Public Signature (SEAL)

Notary commission expiration date