Arkansas Department of Health
Massage Therapy Section
4815 West Markham Street, Slot #8
Little Rock, AR 72205

OUT OF STATE LICENSE VERIFICATION

The application for licensure as a Massage Therapist in the State of Arkansas requires this form to be completed by each State Board where I hold or have ever held a license. By signing below authorizes you to release all information in your files about me that is favorable or otherwise.

Section I (Completed by Applicant). Please type or print clearly.

Applicant Name ___________________________ License Number __________________

Applicant’s Signature ___________________________ Date ___________________________

Address _________________________________________________________________________________

P O Box or Street No.                          City                             State                      Zip

Telephone Number (include area code) _____________________________ Date of Birth ________________

Section II. (Completed by out-of-state licensing authority)

State of ___________________________________________.

This certifies that ______________________________________ is:

(Applicant’s Name)

Registered [ ]          Certified [ ]          Licensed [ ]  as a ___________________________________________

Current status of this license/license/certification is:
Active [ ]          Lapsed [ ]         Inactive [ ]          Denied ** [ ]          Suspended** [ ]          Revoked** [ ]

Effective date of License/Registration/Certification________________________________________________

**Please attach a copy of the Findings of Fact and Decision and Order.

License/Registration/Certification issued based on:
[ ] Education Requirements   [ ] Endorsement/Reciprocity
[ ] State Examination    [ ] National Examination

Qualifications for licensure in this state are:

a. Total hours of education ________
b. Number of hours required in Swedish Massage ________
c. Number of hours required in Anatomy & physiology ________
d. Written examination required? Yes [ ]       No  [ ]
e. Practical examination required? Yes [ ]       No  [ ]

I certify that the above information is correct and true. I have enclosed a copy of the requirements for this state.

Name of Agency _________________________________ Address _________________________________

_________________________________  Typed Name _________________________

Title _______________________________________  Date _________________________

(STATE SEAL)

Revised January 2016