



Nevada State Board of Massage Therapy

1755 E. Plumb Lane Suite 252
 Reno, NV 89502
 Phone (775) 687-9955
 Fax (775) 786-4264

Email: nvmassagebd@lmt.nv.gov
Website: <http://massagetherapy.nv.gov>

TERMINATION OF PROBATION

Please type or print legibly all portions of this application for termination of probation. Please complete this document in its entirety and return the original to the Nevada State Board of Massage Therapists at the address shown above. Use N/A for items not applicable. Incomplete applications will not be processed.

Applicant Name Last		First	Middle Initial
List all other names previously or currently being used by you			
Residence address (do not list Post Office boxes or mailbox drop addresses)			
Street	City	State	Zip
Residence address (if less than 1 year)			
Street	City	State	Zip
Mailing address (if different than the residence address)			
Street or PO Box	City	State	Zip
Business Name:			
Business Address			
Street	City	State	Zip
Home Phone	Cell Phone	Business Phone	Gender
			Male Female
Social Security Number		Date of Birth	Place of Birth

Application Screening Questions (use additional sheets of paper if needed)

<input type="checkbox"/> Yes <input type="checkbox"/> No	1. Have you ever had any disciplinary proceedings instituted against you relating to your license to practice massage? If yes, complete the following: Date of Revocation/suspension/surrender/ or any other disciplinary action: _____ Licensing Agency/jurisdiction that took action: _____ Name and Address of Employer/supervisor: _____ _____ Reason for action: _____
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<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>2. Have you ever been arrested or convicted, within the 10 years immediately preceding submission of this application, of a felony or for any crime involving violence, prostitution or any other sexual offense?</p> <p>If yes, complete the following:</p> <p>Date of Charge/offense: _____</p> <p>Name and Address of Law Enforcement Agency: _____</p> <p>Charge: _____</p> <p>Disposition: _____</p>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>3. Do you currently use any chemical substances that would in any impair or limit your ability to practice the full scope of massage?</p> <p>If yes, you must submit:</p> <ul style="list-style-type: none"> a. A letter of explanation that addresses the impairment or limitations of practice b. A letter of reference from you current/last employer c. A copy of your last employment evaluation d. If you are using the chemical substance as a confirmed medical necessity, a letter from your treating practitioner documenting the diagnosis and medical necessity for the use of chemical substances, including any practice limitations.
<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>4. Are you currently in recovery for chemical dependency, chemical abuse or addiction?</p> <p>If yes, you must submit:</p> <ul style="list-style-type: none"> a. A letter of explanation describing your recovery experience, including length of continuous recovery, treatment, and current recovery activities b. Documentation from knowledgeable individual(s) documenting your length of sobriety c. Documentation of inpatient or outpatient chemical dependency treatment.
<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>5. Do you currently have a medical or psychiatric/mental health condition which in any way impairs or limits your ability to practice the full scope of massage?</p> <p>If yes, you must submit:</p> <ul style="list-style-type: none"> a. A letter of explanation regarding your condition, whether temporary or permanent, including diagnosis, past hospitalizations, date of last treatment, current treatment plan, and how your condition may interfere with your ability to practice the full scope of massage safely b. Documentation from treating practitioner regarding the diagnosis, (Axis I-V for psychiatric diagnosis), medications, current status and treatment plan, the extent of condition, and statement regarding your ability to carry out massage duties reliably and with good judgment.



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Affidavit of Applicant / Authorization of Release

I, _____, certify that I am the person described and identified in this application;

I have answered all the questions truthfully and completely, and any documents that I have provided in support of my application are, to the best of my knowledge, accurate.

I authorize all institutions or organizations, including educational institutions and organizations, my references, employers (past and present), business and professional associations (past and present) and all governmental agencies and municipalities (local, state, federal and foreign) to release to the Nevada State Board of Massage Therapists any information, files or records required by the Nevada State Board of Massage Therapists in connection with processing this application for termination of Probation.

I understand that furnishing false or misleading information or failing to furnish required information on this application may be cause for the denial, suspension or revocation of my license to practice Massage Therapy in the State of Nevada.

Signature of Applicant: _____ Date: _____

State of _____

County of _____

Signed and sworn to before me this _____ day of _____ 20____ by _____, who personally appeared before me.

 Notary Public Signature

 Notary commission expiration date