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

VERIFICATION OF LICENSURE

DATE: _____

I am requesting a certification of my licensing records to be sent to the State of _____

At the following address: _____

_____

_____

The following is information needed to properly ensure that your records are pulled to obtain the certification:

Full name: _____
First Middle Last

Current address: _____
Street Address Apt #

_____
City State Zip

Birth date: _____ Phone #: ( ) _____ Social Security #: _____
Place of Birth _____

I hold a license as a Massage Therapist, Reflexologist or Structural Integration and my license number is: _____

Other names I have used are: _____

Enclose a $10.00 fee in the form of a **MONEY ORDER or CASHIER'S CHECK ONLY** made payable to Nevada State Board of Massage Therapy. (NSBMT)

Mail this form to: NSBMT
1755 E. Plumb Lane Suite 252
Reno, NV 89502

Signature: _____ Date: _____