Douglas A. Ducey,
Governor

Arizona State Board of
Massage Therapy
"Protecting the Public's Health"

1740 West Adams, Suite 3401
Phoenix, Arizona 85007

E: info@massageboard.az.gov
W: https://massagetherapy.az.gov

VERIFICATION OF NON-ARIZONA MASSAGE THERAPY LICENSE

Instructions (to applicant): Please type or print in the following fields of the *upper portion only* and when complete, send it directly to each jurisdiction in which you either hold, held or have applied for a massage therapy license. The other jurisdiction will complete the lower portion and return it directly to the Arizona State Board of Massage Therapy. **Please note:** Each jurisdiction *may* require a fee and that fee must be submitted along with this form.

Last Name _____ First Name _____ Middle Name _____

Street Address _____

City _____ State _____ Zip Code _____ Phone Number (include area code) _____

Last 4 Digits of SSN _____ Date of Birth _____ Please list all other names, including former/maiden or other aliases _____

I authorize the release of all pertinent information, favorable or otherwise, to the Arizona State Board of Massage Therapy

Applicant's Signature _____ **Date** _____

Instructions (to other jurisdiction): Please complete following fields, sign and return it to the Arizona State Board of Massage Therapy to the address listed above. Emailed responses will be accepted at **info@massageboard.az.gov**. Please affix your authorizing Seal.

License Number _____ Issue Date _____ Current Status _____ Expiry/Cancellation Date _____

Was the license obtained by reciprocity/endorsement? **Yes** ☐ **No** ☐ If yes, from which jurisdiction? _____

Is the applicant currently the subject of an unresolved complaint in your jurisdiction? **Yes** ☐ **No** ☐
If yes, please attach details.

Has the applicant's license ever been denied, suspended, revoked, allowed to be surrendered, placed on probation or otherwise incurred any disciplinary proceedings? **Yes** ☐ **No** ☐
If yes, please attach details.

Has the applicant been licensed for *at least* two of the last five years? **Yes** ☐ **No** ☐
If no, please attach details.

Affix Seal Here

Name of Person who Completed Form _____ Title _____

Jurisdiction Name and Street Address _____

City _____ State _____ Zip Code _____ Phone Number (include area code) _____

I certify, to the best of my knowledge, that the information provided is true and accurate.

Representative's Signature _____ **Date** _____

The Americans with Disabilities Act: Persons with disabilities may request reasonable accommodations, such as sign language interpreters. Requests should be made as early as possible to allow time to arrange the accommodation. This document is available in alternative format upon request.