ARKANSAS DEPARTMENT OF HEALTH
MASSAGE THERAPY SECTION
4815 West Markham, Slot 8
Little Rock, AR 72205-- (501) 683-1448

Military Reciprocity Form

Qualifications and Instruction for Licensure set forth in ACA §17-86-101 also known as the Arkansas Massage Therapy Act;

Military Reciprocity Requirements:

1. Applicant must be 18 years of age or older;
2. Identification - Valid **Photo** ID – (Driver's License, State Issued ID Card, Passport, or US Military ID);
3. Social Security Card – A copy of your social security card;
4. A copy of the Sponsors Active Duty Military Orders as required by §17-1-106;
5. Out of State License Verification-An out of state license verification form must be completed by each State Board or office where you hold or have ever held a massage therapy license use the following link for form. http://www.healthy.arkansas.gov/programsServices/hsLicensingRegulation/MassageTherapy/Documents/OOSVerification.pdf
6. Application – (attached below)
7. Payment - $155.00 (non-refundable)

THE $155 NON-REFUNDABLE FEE IS DUE AT THE TIME YOU SUBMIT THE FORM AND THE REQUIRED ATTACHMENTS. THE FEE AND APPLICATION EXPIRE ONE (1) YEAR AFTER APPLICATION DATE.

Arkansas Department of Health Massage Therapy Section Non-refundable Application Fees

- Application Fee $ 75.00
- License Fee $ 80.00
  Total Fee $155.00

- Above fees are payable to ADH – Massage Therapy.

Contact Information

Arkansas Department of Health – Massage Therapy Section

Mailing Address:	Physical Address:
4815 West Markham, Slot #8	4815 West Markham
Little Rock, AR 72205	Little Rock, AR 72205
Phone: 501-683-1448	website: www.healthy.arkansas.gov/cos

A massage therapy license will be issued when all the above has been received in the Section's office.

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All applicants for licensure must complete this form and submit it with the appropriate documentation and $155 ***NON-REFUNDABLE*** *application fee. Failure to complete all parts of the application or omission of required documents will delay the review and process of your application. Payment must be made payable to ADH-Massage Therapy. (Personal check, cashier's check or money orders are accepted)* ***All applications and fees expire one year from application date.***

Applicant Information:

Last Name	First Name (no nickname)		Middle Name		
Mailing Address	Apt. #	City	County	State	Zip Code
Physical Address (If different)	Apt. #	City	County	State	Zip Code
Telephone Number ( )	Gender MALE FEMALE		Marital Status		
Social Security Number	Date of Birth		Place of birth (city/state/country)		

Race:	Military Status:
____Black ____White ____Am. Indian ____Hispanic ____Asian ____Alaskan Native	_____Active duty military personal stationed in the State of Arkansas _____Returning military veteran applying within one (1) year of his or her discharge from active duty _____Spouse of an active duty military personal or veteran ____Spouse of a military veteran applying within one (1) year of his or her discharge from active duty

Disclosure of a social security number by an applicant is mandatory under Ark. Code Ann. §17-1-104(a) which states: ***"On and after July 1, 1997, all persons, agencies, boards, commissions, or other licensing entities issuing any occupational, professional, or business license pursuant to titles 2-6, 8, 9, 14, 15, 17, 20, 22, 23, and 27 of the Arkansas Code Annotated shall record the name, address, and social security number of each person applying for such a license."***

Have resided in any State other than Arkansas? List address & length of residency (Attach additional sheets if necessary)

Previous Address	Suite/Apt			How long at previous address
City	State	Zip	County	
Previous Address	Suite/Apt			How long at previous address
City	State	Zip	County	

Massage Therapy Training:

School Name			Number of In-Classroom Hours Completed
Address	Suite/Apt		
City	State	Zip	County
Director's Name	Phone	Enrollment Date	Graduation Date

Applicant Signature: By signing this application, I certify that the information provided is correct to the best of my knowledge and that I understand that false statements will be sufficient grounds for the Board to take disciplinary action.

Date	**Applicant's Printed Name**	**Applicant's Signature**