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

SCHOOL RELOCATION APPLICATION

PLEASE **PRINT** USING BLUE OR BLACK INK

INSTRUCTIONS: File this application to change the address of your location.

SECTION A -- SCHOOL INFORMATION CURRENTLY ON FILE WITH THE MASSAGE THERAPY SECTION *(PRIOR TO CHANGE)*

SCHOOL NAME			License Number		
MAILING ADDRESS	SUITE	CITY	COUNTY	STATE	ZIP CODE
PHYSICAL ADDRESS	SUITE	CITY	COUNTY	STATE	ZIP CODE
OWNERSHIP INFORMATION (CIRCLE ONE)	SOLE PROPRIETORSHIP	PARTNERSHIP	CORPORATION		
NAME OF OWNER(S)			Telephone Number ( )		

SECTION B -- RELOCATION INFORMATION

NEW MAILING ADDRESS	SUITE	CITY	COUNTY	STATE	ZIP CODE
NEW PHYSICAL ADDRESS	SUITE	CITY	COUNTY	STATE	ZIP CODE

Days Closed (CIRCLE ALL THAT APPLY)	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY

RELOCATION DATE	TELEPHONE NUMBER ( )	Email Address (REQUIRED)

In signing this application, you are certifying that:

1. The information provided on this form is correct to the best of your knowledge.
2. You are the school or are authorized to act as the owner's agent.
3. You have read this form, the laws and rules.
4. You have complied with all laws and rules governing cosmological schools.
5. You will close your establishment if the Inspector finds the establishment not in compliance with applicable rules.

Owner's Signature	Today's Date

ARKANSAS DEPARTMENT OF HEALTH
MASSAGE THERAPY SECTION

SCHOOL INSTRUCTOR FORM

1) Every Massage Therapy school shall at all times be under the immediate supervision of a School Instructor.
2) A School Instructor must be currently licensed as a Massage Therapy instructor.

INSTRUCTOR'S NAME_____Phone #_____

LICENSING RECORD: LMT:_____ years, from _____ to _____ Lic ID#_____
MO & YR MO & YR

Instructor:_____ years, from _____ to _____ Lic ID#_____
MO & YR MO & YR

EXPERIENCE RECORD: (Experience that qualifies for Instructor Position)
MASSAGE THERAPIST EXPERIENCE (Employment date state Months and Years)

Employer's Name	Spa Name	City	State	Phone #	Emp Dates Beg/End
Employer's Name	Spa Name	City	State	Phone #	Emp Dates Beg/End
Employer's Name	Spa Name	City	State	Phone #	Emp Dates Beg/End

INSTRUCTOR EXPERIENCE (Employment date state Months and Years)

Employer's Name	School Name	City	State	Phone #	Emp Dates Beg/End
Employer's Name	School Name	City	State	Phone #	Emp Dates Beg/End
Employer's Name	School Name	City	State	Phone #	Emp Dates Beg/End

CERTIFICATION

I, _____, do hereby certify that the employment record contained on this form is an accurate record of my employment history.

DATE: _____ INSTRUCTOR'S SIGNATURE_____

I, _____, d/b/a _____ do hereby certify that the above-named individual is under my employment in the capacity of INSTRUCTOR.

DATE:_____ OWNER'S SIGNATURE_____

ARKANSAS DEPARTMENT OF HEALTH
MASSAGE THERAPY SECTION

AUTHORIZED DESIGNEE CERTIFICATION

I, _____, d/b/a _____
OWNER'S NAME SCHOOL NAME

do hereby designate and authorize _____ to accept service of notice
DESIGNEE'S NAME
from the Department and to transact all business negotiations on behalf of the school, including answers to citations for hearing, and compliance with rulings issued by the Department.

DATED THIS _____DAY OF _____, 20____.

_____
OWNER/ADMINISTRATOR'S SIGNATURE

_____
DESIGNEE'S SIGNATURE