

MD BOARD OF CHIROPRACTIC & MASSAGE THERAPY EXAMINERS
REINSTATEMENT FOR RENEWAL APPLICATION FOR 2010-2012



NAME: _____
 BD LIC. / REG. NO.: _____
 CURRENT PHONE NO.: _____

BOARD USE ONLY

Date RECEIVED: _____
 APPROVAL Initials / Date: _____ / _____
 Reviewer/Date: _____ / _____
 CEU Reviewer/Date: _____ / _____
 Entered Database: _____
 Check/MO No.: _____
 Comment(s): _____

INVESTIGATOR'S Initials: _____ / Date: _____
 Background: COMPLETE PENDING

REINSTATEMENT FOR RENEWAL FEES:

LICENSE MASSAGE THERAPIST = L.M.T.

REGISTERED MASSAGE PRACTITIONER = R.M.P.

Payment must be by personal check, certified check, or money order payable to the *“Board of Chiropractic & Massage Therapy Examiners”* Other fees may apply. **Cash, credit cards, and walk-in payments are not accepted.**

- ◆ **REINSTATEMENT Application Fees for (LMT)** – **\$678.00** (Includes \$200.00 late fee, \$200.00 reinstatement fee, \$250.00 renewal fee and mandatory biennial assessment of \$28.00 by the Maryland Health Care Commission which applies to all Maryland Health Care Practitioners.)
- ◆ **REINSTATEMENT Application Fees for (RMP)** – **\$650.00** (Includes \$200.00 late, \$200.00 reinstatement fee, and \$250.00 renewal fee.)

APPLICANTS MUST COMPLETE ALL SECTIONS OF THIS APPLICATION. PRINT LEGIBLY OR TYPE.

A. CURRENT MAILING ADDRESS: _____
 _____ Home Ph. No. _____ Mobile No. _____

* PREVIOUS ADDRESS: _____

B. E-MAIL ADDRESS: *(Please provide your current, valid e-mail address for better communication from the Board and CEU providers)* > E-Mail: _____

C. WORKERS' COMPENSATION INSURANCE INFORMATION *(Required per Health Occupations Art. §1-202):*
Please direct inquiries to 410-864-5100 or visit the WCC website at <http://www.wcc.state.md.us> for more info.

I HEREBY CERTIFY THAT:

- _____ I do not practice in Maryland.
- _____ I practice in Maryland and am **NOT** an employer.
- _____ I practice in Maryland and employ one or more persons. Listed below is my required Workers' Compensation Insurance information.

Insurance Co.: _____ **Policy No.:** _____ **Exp. Date:** _____

D. PROFESSIONAL COMPETENCY & BACKGROUND

Please write "YES" or "NO" to each question below. All "yes" answers must be explained in your own words on a separate sheet. Include all details, dates, and resolutions to the matter. **NOTE: ALL QUESTIONS MUST BE ANSWERED OR APPLICATION WILL BE RETURNED.**

- _____ 1. **Within the past 2 years**, have you been addicted to, or are currently dependent on alcohol, any drug (prescription or non-prescription), or any controlled substance?
- _____ 2. **Has ANY state** licensing, certification or disciplinary Board or comparable body in any federal, state, municipal or Armed Forces ever taken any action against your license, certification, or registration, including this Board?
- _____ 3. **Within the past 2 years**, have there been any outstanding complaints, investigations, charges, or allegations pending against you by any of the aforementioned bodies?
- _____ 4. **Within the past 2 years**, have you had a physical or mental illness, or injury/disability that impaired or impairs your ability to practice?
- _____ 5. **Within the past 2 years**, have you pled *guilty*, *nolo contendere*, *no contest*, or been **convicted** or received **probation before judgment** of any criminal act, including DWI or DUI of alcohol or controlled substances?
- _____ 6. **Within the past 2 years**, has any hospital, HMO, managed care organization, or related health care entity or employer denied you privileges or employment, denied application for employment, or did not renew your contract for a reason or reasons related to your practice?
- _____ 7. **Within the past 2 years**, has a malpractice civil suit or action been filed against you or has a claim been made against you or a settlement or award had been made against you relating to your practice?

E. CONTINUING EDUCATION (TOTAL REQUIRED = 24) & CPR CERTIFICATION:

You must submit **copies** of your CEU certificates and a **copy** of your current valid qualification in CPR along with this form. **Reinstatement forms submitted without copies of valid CEU completion certificates and a copy of your current active CPR card WILL NOT BE PROCESSED and may be returned to you.**

- F. Active **LMT** Fee: \$278.00 (Includes Health Care Commission Fee of \$28.00) _____
- Active **RMP** Fee: \$250.00 _____
- Duplicate Fee: \$ 40.00 X _____ (\$20.00 during Biennial Renewal Period) . = _____
- Inactive Fee: \$ 50.00 _____
- Late Fee: \$200.00 (In addition to the Active or Inactive Fee – pay on or after 11/1/2010) _____
- Reinstatement Fee: \$200.00 (In addition to the Renewal and Late Fee – pay on or after 12/1/2010) _____
- Reactivation Fee: \$100.00 (In addition to the renewal fee when changing from **Inactive to Active** status) _____
- Check(s) or money order(s) number(s): _____ TOTAL FEE(S): \$ _____

***Did you remember to:** Enclose payment, answer all questions, attach copies of CEU completion certificates, attach a copy of current CPR card, attach document(s) AND explanation letter (if you answered "YES" in Section "D"); then *sign* and *date* the bottom of this form?

I AFFIRM AND ATTEST THAT THE INFORMATION I HAVE GIVEN ON THIS APPLICATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

PRINT/TYPE APPLICANT FULL NAME
(FIRST NAME, MIDDLE NAME, LAST NAME)

APPLICANT SIGNATURE

LIC. / REG. No. DATE