# North Dakota Board of Massage

PO Box 3141, Bismarck, ND 58502-3141
ndbmt@aptnd.com www.ndbmt.org

**To inquire if a Continuing Education Course is approved.**

**Name of Massage Therapist**:

_____

First Middle Last

Address: _____ City/State: _____Zip Code: _____

North Dakota License Number: _____Email Address: _____

Work Phone: _____ Cell Phone: _____

Business name: _____

Business address: _____

**Course Information:**

Name of course: _____

Instructor's name: _____

Instructor's phone number: _____ Email address: _____

Proposed Location(s) of course(s): _____

Proposed date(s) the course is offered: _____
Proposed number of Continued Education hours this course will provide: _____
Are any hours "hands-on application" hours? Yes__ No__, If, yes, list the amount of hours: _____
Are any hours being provided by remote means? Yes __ No __.
Please be advised that ONLY ten (10) hours can be applied toward the total twenty-four (24) hours needed for the licensing period. Even though more than ten (10) hours may be submitted, you are still responsible for the required fourteen (14) classroom hours during the licensing period.

Has this course been approved by NCBTMB or other associations and states? Yes _____ No _____ If yes, list others: _____

**After completing this course, if approved, it is your responsibility keep a copy of the certificate of completion on file.** You may be required to submit a copy of this certificate with your biennial license renewal.

**Signature of Licensed Massage Therapist:_____Date: _____**