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COMMISSIONER, DIVISION OF
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CERTIFICATION OF STANDING REQUEST

Instructions:

1. Applicant – Complete upper portion of form and forward to each jurisdiction where you have held any professional license or certification. (This form may be photocopied if necessary).
2. The licensing agency is to complete the lower portion of this form and submit it either to the applicant in a sealed envelope or mail directly to the Commonwealth of Massachusetts Board of Registration of Massage Therapy at the address listed above in an envelope with the agency's return address printed on it.

THIS FORM WILL NOT BE ACCEPTED IF THE ENVELOPE HAS BEEN OPENED OR IF IT APPEARS THE APPLICANT HAS WRITTEN IN THE LOWER PORTION OF THE FORM.

To be completed by Applicant.

Last Name	First Name	Middle Name

Street Address	City	State
		Zip Code

Type of License Granted	License #	Date Issued

I authorize the release of all pertinent information, favorable or otherwise, to the Commonwealth of Massachusetts Board of Registration of Massage Therapy.

Signature of Applicant	Date of Request
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To be completed by licensing agency only. Applicant should not write below this point.

This is to certify that the above named individual was issued license number: _____

Title of Applicant's License: _____ Date License Issued: _____

Lapsed/Expired on: _____ Credential current through: _____

Please answer the following questions. If the answer to any question is YES, explain on the reverse side of this form or attach appropriate documentation supporting your answer.

1. Has the applicant's credential ever been suspended or revoked? Yes No
2. Are there any complaints and/or disciplinary action taken or pending against this applicant? Yes No
3. Does this credential have any restrictions or limitations on it? Yes No

Signature of Official: _____ Date: _____

Printed Name of Official: _____

Official Title: _____

Agency

Seal

Licensing Agency Name: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

