



REMEDIAL MASSAGE THERAPISTS ASSOCIATION

FULL MEMBERSHIP APPLICATION

Personal Information

First Name: _____ Last Name: _____ Initial: ____
Personal Email: _____
Date of Birth: (DD/MM/YYYY) _____ Gender: Male Female
Home Telephone: (_____) _____ Cell: (_____) _____
Home Address: _____
City: _____ Prov: _____ Postal Code: _____

Education and Training- We require documented proof of completion of 2200 hours of education from a recognized school of massage; include transcripts from 1st and 2nd year.

1. School Name: _____
Address: _____
Date of Graduation (DD/MM/YYYY): _____ Number of Hours: _____
Document awarded (please attach a copy):
 Certificate or Diploma **and** Transcript

2. School Name: _____
Address: _____
Date of Graduation (DD/MM/YYYY): _____ Number of Hours: _____
Document awarded (please attach a copy):
 Certificate or Diploma **and** Transcript

The following information will be posted on the website under “**Find a Therapist.**”

Professional Information

Business Name: _____
Business Website: _____
Business Email: _____
Business Telephone: (_____) _____ Fax: (_____) _____
Business Address: _____
City/Province: _____ Postal Code: _____

Modalities

- | | | |
|---|--|---|
| <input type="checkbox"/> Active Release | <input type="checkbox"/> Integrative Manual Therapy | <input type="checkbox"/> Sport Massage
(including athletic taping and bracing) |
| <input type="checkbox"/> Acupressure | <input type="checkbox"/> Joint Mobilization | <input type="checkbox"/> Strain/Counterstrain |
| <input type="checkbox"/> Alexander Method | <input type="checkbox"/> Manual Lymphatic Drainage | <input type="checkbox"/> Structural Integration |
| <input type="checkbox"/> Aromatherapy | <input type="checkbox"/> Muscle Energy Technique | <input type="checkbox"/> Suction Cupping |
| <input type="checkbox"/> Bioflex Laser Therapy | <input checked="" type="checkbox"/> Myofascial Release | <input checked="" type="checkbox"/> Swedish Massage |
| <input type="checkbox"/> Bowen Therapy | <input type="checkbox"/> Lensen™ | <input type="checkbox"/> TENS Therapy |
| <input type="checkbox"/> BrainGym | <input type="checkbox"/> Lomi-Lomi | <input checked="" type="checkbox"/> Therapeutic Massage |
| <input type="checkbox"/> Craniosacral | <input type="checkbox"/> Neuromuscular Therapy | <input type="checkbox"/> Therapeutic Touch |
| <input checked="" type="checkbox"/> Deep Muscle | <input type="checkbox"/> Onsen | <input type="checkbox"/> Touch for Health/RESET |
| <input type="checkbox"/> Feldenkrais Technique | <input type="checkbox"/> Orthobionomy | <input type="checkbox"/> Traditional/Thai/Thai Yoga
Massage |
| <input type="checkbox"/> Fire Cupping | <input checked="" type="checkbox"/> Pre & Post Natal Massage | <input type="checkbox"/> Trager |
| <input type="checkbox"/> Healing Touch | <input type="checkbox"/> Raindrop Therapy | <input checked="" type="checkbox"/> Trigger Point |
| <input type="checkbox"/> Hot Stone Therapy | <input type="checkbox"/> Reflexology | <input type="checkbox"/> Visceral Manipulation |
| <input checked="" type="checkbox"/> Hydrotherapy | <input type="checkbox"/> Reiki | <input type="checkbox"/> Yoga |
| <input type="checkbox"/> Indian Head/Foot Massage | <input checked="" type="checkbox"/> Relaxation Massage | |
| <input type="checkbox"/> Infant Massage | <input type="checkbox"/> Shiatsu | |
| | <input type="checkbox"/> Shockwave Therapy | |

A certificate of completion must be submitted for any modality indicated that was not included in your 2200 hours of education in order for the liability and malpractice insurance to cover you to perform that treatment. If you are practicing one of the above modalities and RMTA does not have a certificate on file for you, the insurance will not cover you. Please note there is an additional \$100 surcharge for Yoga and \$150 surcharge for Fire Cupping that is payable directly to the broker.

Have you ever been a member of a massage therapists association or massage therapy college?

YES NO **If you currently hold a membership please provide a letter of good standing.

If yes, please name the association(s) / college(s), your membership number, and when you had a membership:

Has a massage therapists association or college ever denied you admittance into their organization?

YES NO

If yes, please state the organization and their reasoning:

Has your membership ever been cancelled with a massage therapy association or college?

YES NO

If yes, please state the organization and the reason for cancellation:

Did you ever have a complaint filed against you while being a member of a massage therapists association or massage therapy college? YES NO

If yes, please state the organization involved and describe the details of the complaint:

Personal Information Protection Act (PIPA)

Personal information is used only for internal database purposes. In the event that a member's residential address is also their business address, it is understood and agreed by the member, as signed below, that this information may be given out by the RMTA for business purposes only.

In order to provide and improve member services, the RMTA collects the personal and business related information contained within this application. Other than your name, city, province, membership status and the above mentioned business contact information, information you provide on this form is confidential and will only be used for the provision of member services and statistical reporting in accordance with the PIPA.

The signature below is to be considered as consent to the collection, use and disclosure of personal information as described. The signature below is also considered as consent for the Registered Massage Therapists Association to publish business contact information and treatment types available in various formats as required from time to time, including the Find a Therapist area of the RMTA website.

Signature: _____

I, the undersigned, declare that the information provided and statements made in this application and any attached documents are true.

Signature: _____ **Date:** _____

Requested Effective Date: _____

*If you would like your application effective as soon as possible, please put **ASAP**. Effective dates cannot be before the submission of your application.*

Application Checklist

- Completed Application Form**
- Criminal Record Check**
**completed within the last 90 days*
- Copy of Education Credentials**
**including transcripts from 1st and 2nd year*
- Copy of current Standard First Aid & C CPR**
- Letter of good standing from current Association or Regulatory College (if applicable)**
- Indicate Payment Method:**
 - Cheque** (enclosed with application)
 - Email Money Transfer** (you will receive instructions once your application is confirmed)
 - Credit Card** (you will receive an invoice from PayPal via email with further instructions for payment)

Membership Fee Payment Schedule	
Requested Effective Date	Cost
Jan, Feb, Mar	\$250
Apr, May, Jun	\$187.50
Jul, Aug, Sep	\$125
Oct, Nov, Dec	\$67.50
*Fees for the following year must be paid at the same time	+ \$250= \$317.50

Please Note: Incomplete applications will not be processed until all information is submitted. No refunds will be given for cancellation of membership for any reason.