

South Dakota School of Massage Therapy, Inc.
902 West 22nd Street
Sioux Falls, South Dakota 57105
605-334-4422

Attach
photo

Date _____

Name _____
Last First Middle

Address _____
Street City State Zip

Phone (____) _____

Age _____ Gender (M/F) _____ Date of Birth _____

Place of Birth _____
City State Country

Are you a U.S. citizen? (Y/N) _____ Marital Status _____

Social Security Number _____

EDUCATION

High School _____ Graduation Date _____

College _____ Major _____ Minor _____

Graduation Date _____

Graduate Studies _____

Vocational School Training _____

EMPLOYMENT

Current Employer _____

Address _____

Position _____ Supervisor _____

Length of Employment _____

Other Employers within the last 3 years _____

Have you ever been convicted of a crime? _____

If so, please explain _____

How did you hear about the South Dakota School of Massage Therapy? _____

Please list 3 personal character references who are not related to you, and have known you for at least 3 years. Please provide a letter of reference from each.

1) _____ (____) _____
Name Address Phone

2) _____ (____) _____
Name Address Phone

3)) _____ (____) _____
Name Address Phone

MEDICAL INFORMATION

Do you have any medical problems that would hinder your SDSMT training? _____

Do you have, or have you ever had a contagious disease? _____

Do you have any physical problems or handicaps? _____

Do you have any medical problems or handicaps? _____

If yes, please explain _____

How will your tuition be paid? _____

- Please submit a short autobiography outlining your interests, philosophy of health and any experience in health care and/or massage therapy. Explain why you want massage therapy training.

FOR OFFICE USE ONLY

Date received _____ Application Fee received _____