M.T. Wellness – Masters Center
Training for
Certification in Medical Restorative Massage Therapy©

Advanced training for Licensed Massage Therapist

OFFICE OF ADMISSIONS

1151 Bethel Rd, Suite 303

Columbus, OH 43220-2775

www.MTWellnessClinic.com

Phone: 614-273-0810 *Email: Info@MTWellnessClinic.com* ***Fax: 614-273-0173***

Welcome to the M.T. Wellness - Masters Center application process! Congratulations on embarking on your professional and financial path to success! Scheduling priority will be given in the order in which applications are completed.

Application Checklist / Date Completed ______________

Complete and send the following documents to M.T. Wellness – Masters Center:

- ✓ Complete **Application for Admission** / ____________
- ✓ Authorize Reference Verification on Application form / ____________
- ✓ Attach current Resume with List of Continuing Education and Essay on why you want to be certified in Medical Restorative Massage Therapy/ ___________
- ✓ Copy of current pocket-card of unrestricted Ohio license as Massage Therapist (OH LMT) and copy of Limited Practitioner's Certificate from State Medical Board of Ohio / ____________
- ✓ Proof of current Professional Liability Insurance, with coverage amount no less than $1,000,000.00 (one million dollars) / ____________
- ✓ Send a non-refundable, non-transferable application fee payment of $100 / ____________

- ✓ Complete **Part A** of the **Recommendation Form** on both copies / ____________
  -Send with an addressed (to M.T. Wellness-Masters Center), stamped envelope to an academic (school) reference and an employment reference (employer or fellow employee). Ask them to complete **Part B** and mail directly to the M.T. Wellness – Masters Center as soon as possible.
- ✓ Get a physical (an ATB Test is required for Admissions) and have **Physical Health Examination Form** completed by your physician (MD or DO) and sent to M.T. Wellness – Masters Center /______________
- ✓ Complete the **Request for Massage Therapy School Transcripts** form. Have official transcripts sent directly to M.T. Wellness – Masters Center from prior accredited School of Massage Therapy/__________
- ✓ Request, from a vendor that participates in "National WebCheck (NWC)" that criminal records check results from both BCII and FBI be sent directly to M.T. Wellness – Medical Model Massage Institute (See informational sheet attached) / _______________
- ✓ Visit the M.T. Wellness – Masters Center / _______________
- ✓ Interview with the Director / ______________
- ✓ Pass the Entrance Exam / _______________

M.T. Wellness Clinic does not discriminate on the basis of age, race, color, national origin, religion, sex, sexual orientation, political affiliation belief or disability with regard to admission, access, treatment or employment.

Please mail completed Application, application fee and all supplementary documents to the address above as soon as possible to receive priority in scheduling. Feel free to call with questions. Thank you!

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Fax: 614-273-0173

Application for Admission

Phone: 614-273-0810

Date of application: ____/____/______ Social Security Number: _____/_____/______

Last Name: __________________________ First Name: ___________________ Middle: _______________

Maiden Name/Other Name(s) Used: ____

Permanent Address: ________________________________City:___________ State: _____ Zip: ___________

Current Address (if different from above):____

Home Phone: (___)-____-_______ Work: (___)-_____-________ Mobile: (___)-____-_____

Date of Birth: ____/____/_____ Sex: ___F ____M OH LMT license number: ___________________

Country of Citizenship: ________________ Marital Status (optional): _____________

Please attach copy of current Resume and Admissions Essay.

In case of Emergency, please contact:

____

Relationship to self: _______________________________

Address: ___________________________________ City: ___________________ State: _____ Zip: _________

Phone Day: (____) - _____-_______ Phone Eve: (____) - ______-_________

Education: Circle highest year completed in each: High School 1 2 3 4 GED College 1 2 3 4 5 6 78

High School

Name & Location	From	To	Diploma	GPA	Extracurricular Activities

College, Graduate School, Massage Therapy School, Vocational or Professional Training

Name & Location	From	To	Degree	Major	Extracurricular Activities/Other

I authorize all schools, credit bureaus and law enforcement agencies to supply information concerning my background. I understand that I have the right to request disclosure of the nature, scope, and results of such an inquiry. I herby attest that all information provided in this application is true and accurate. I understand that is any statement herein is not true, enrollment may be denied.

Signature________________________________ Printed Name of Applicant__________________________________

Date_____/_____/_____

How did you hear about the M.T. Wellness – Masters Center? ___ Newspaper ___ Internet ___ Other

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Request for Massage Therapy School Transcripts

Complete this form and mail it, with appropriate fee, to your Massage Therapy School

Name of Applicant (print) ____

SSN _______-_____-________

Name on Massage Therapy School Transcript (print) ____

Date of Birth ____/____/____ Phone (____) - ______- _________

Home Address ____

Massage Therapy School ____

School Address ____

School Phone number ______________________________

I authorize the above named school to release the documents requested to the M.T. Wellness – Masters Center.

____ ______/______/_______
Signature of Applicant Date

Instructions to Massage Therapy School:

Upon receipt of this form, please forward this form and a copy of the **official transcript** of the applicant to:

M.T. Wellness – Masters Center
1151 Bethel Road, Suite 303
Columbus, Oh 43220-2775

The transcript must show:

- Month, day and year of graduation
- Total credit hours earned & Cumulative Grade Point Average (GPA)
- Intern Applicant's date of birth
- Embossed school seal and/or the hand written signature of a school official and his/her title

Please check to ensure that the above information is included on the transcript. If the transcript is not acceptable, a new one will be requested. Please call with any questions. Thank you.

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Fax: 614-273-0173

Recommendation Form

Phone: 614-273-0810

Part A - To the applicant: Please complete Part A and give this form to your reference.

Applicant Name (print) ____ Date _____/_____/______

Home Address____

Phone: Home- (___) - ____-_____ Work- (___) - ____- _____

Part B - To the referring party: This person has applied to the M.T. Wellness - Masters Center for admission into the Certification in Medical Restorative Massage Therapy© (MRMT). The training is rigorous and will require dedication and commitment.

Please complete the following regarding the applicant. If needed, feel free to use additional pages. Please return in enclosed envelope or fax to: 614-273-0173. This information will be kept confidential. Thank you for your time to assist us in the evaluation of the applicant.

1. Capacity in which you have know the applicant:

2. Length of time you have known the applicant:

3. Ability to relate to others in a mature manner:

4. Integrity in relationships with others:

5. Extent of your knowledge of applicant's ethical behavior:
Ethical Behavior:

6. Capacity to complete tasks:

7. Explain why you would or would not recommend acceptance of the applicant:

8. For Academic Reference: Extent of your knowledge of applicant's academic abilities:
Perceived academic abilities of applicant:

- Ability to generalize and apply academic knowledge

- Ability to assume responsibility for learning

Reference Name (print):__________________________________ **Phone: (___) - ___- ____**

Reference Signature: _____________________________________ **Date:** ________________

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Physical Health Examination Form

(Valid for one year from examination date)

Applicant's Name_______________________________________ Date of Birth ____/_____/______

Address ____

City ________________________________ State __________ Zip Code ____________________

____

Applicant's Signature to Authorize Information Release

Dear Physician,

The above applicant has applied for enrollment to M.T. Wellness - Masters Center to become certified in Medical Restorative Massage Therapy© (MRMT). The Intern practitioner is required to touch other Interns and the general public. During the course of professional training, the Intern will give and receive massage daily. For this reason, the following health clearance is important to the school for both the Intern's well being, as well as the safety of the general public.

Please certify that you have examined the above named applicant and indicate whether or not he/she suffers from any infectious or communicable disease or has any additional mental or physical health conditions, which would prevent him/her from undertaking a rigorous course of study, and safely performing as an Intern of massage therapy.

I certify that I have examined the above named applicant and have determined he/she is:

___ cleared for participation in the above activities

___ not be able to participate for the following reason(s):

____

____

____ The above applicant has had an ATB Test. (Required for Admissions)

____________________________________ ____

Physician's Signature Printed Name

Address____

Phone (___)- ____- ______ Fax (___)- ____-______ Date____/____/______

Please return immediately via mail to:

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Criminal Records Check Required for Admissions

M.T. Wellness – Medical Model Massage Institute requires the same criminal records check that the State Medical Board of Ohio will require for initial Licensure.

Applicants are required to submit a criminal records check completed by both the Ohio Bureau of Criminal Identification and Investigation (BCII) and the Federal Bureau of Investigation (FBI). Applications MUST use the services of a vendor that participates in the "National WebCheck". The Sheriff's offices in all 88 Ohio counties participate in the "National WebCheck". A list of all vendors, searchable by county, is available online at:

http://www.ag.state.oh.us/business/fingerprint/data/index.asp

For Example:

A Fastfingerprints Company
1486 Bethel Road
Columbus, OH 43220
Phone 1-877-932-2435

Monday-Friday 8-5
Saturday 9-12

Ohio BCI & FBI cost $85

Ascertain Screening and Investigation, LLC
170 Mill Street, Suite 200
Gahanna, OH 43230
Phone 1-800-858-2901

Monday-Friday 9-11:30a and 1:30-4p
Or by appointment

Combined BCI/FBI cost $72

Steps for "National WebCheck"

- ✓ Identify a vendor that participates in the "National WebCheck (NWC)
- ✓ Submit your fee directly to the vendor
- ✓ Request that the criminal records check results from both BCII and FBI be sent directly to:

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