THE INSTITUTE OF THERAPEUTIC MASSAGE, INC.

PH #: 866-897-0949 FAX #: 419-523-9152

A PROFESSIONAL EDUCATION FOR A PROFESSIONAL CAREER

APPLICATION INSTRUCTIONS

GREETINGS!

Congratulations, you are ready to proceed to the next step on the path to your future! Everything you will need to enroll in The Institute of Therapeutic Massage, Massage Therapist program is contained herein. Should you have any questions, please do not hesitate to call.

Contents include:

1. Pg. 2, 3, 4 Student Application
2. Pg. 5 Health Certification Form
3. Pg. 6, 7 Personal/Professional References (two)
4. Pg. 8 Request for High School Transcript
5. Pg. 9, 10 State of Ohio, Massage Preliminary Education Form w/instructions
6. Pg. 11, 12 Financial Assistance forms. (Required only if you choose to seek financial assistance.)

Complete Pg.'s 2, 3, and 4 filling in all areas. If a particular area is not applicable to your situation indicate so with N/A. Take Pg. 5 to your personal physician and have him/her fill out the Health Certification Form. Return the completed pg.'s 2, 3, 4 and pg. 5 to the Institute of Therapeutic Massage along with your application fee of One Hundred and Five Dollars ($105.00).

Pg.'s 6, 7 - Contact two individuals not related to you to provide references. Mail or deliver to each a Personal/Professional Reference form. They should return it directly to the School upon completion.

Complete and submit to your High School of Graduation or the Department of Education in the case of a G.E.D. the Request for High School Transcript (pg. 8). Request that they forward the transcript to The Institute of Therapeutic Massage.

Complete the Preliminary Education (PE) form pg.9 following their instructions in detail. Submit a check or money order in the amount of $35.00 made payable to the State Medical Board of Ohio and mail or deliver to the Institute of Therapeutic Massage for our certification. **Note: Name change documents, with respect to name changes must be returned to the Institute along with the PE number application.**

The Financial Assistance forms need to be filled out only if you plan on seeking financial assistance. Please call our offices for specific information as to your situation for proper assistance.

That's all there is to it! If I can be of any help in clarifying anything please do not hesitate to call. I'm glad to be of service.

Sincerely;
Karl U. Meyer, President

Over

9508 STATE ROUTE 65
PO BOX 350
OTTAWA, OHIO 45875-0350

311 E. MARKET ST, SUITE 206
PO BOX 1466
LIMA, OHIO 45802-1466

Ohio Reg.# 02-05-1636T

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STUDENT APPLICATION

Name: ____ Maiden: ___________________

Address: _________________________________ Driver Licenses # _________________

City: _______________________ State: ____ Zip: ________ County: ________________

Phone #: ___________________________ Cell Phone #. __________________________

Social Security #: _____________________ Marital Status: ___________ Sex: ________

Date of Birth: ___________ e-mail:______________________________

Program applying for: (See School Catalog / Handbook page 3 for Start and Completion Dates)

❑ Fall ❑ Winter ❑ Spring ❑ Summer	❑ 12-month ❑ 15-month ❑ 18-month	Program ❑ 900 Hour $ 16,994	❑ Mornings ❑ Evenings ❑ Combination

DO YOU REQUIRE SPECIAL PHYSICAL OR EDUCATIONAL ACCOMMODATIONS? ▢ YES ▢ NO.

If yes please explain: ____

Employment History

List in chronological order, **beginning with most recent.** Include part/full time and volunteer work.

Present Employer: _________________________ May we contact your employer? _____

Address: ______________________________________ Phone #: ___________________

City: _______________________________ State: ___________ Zip: ________________

Occupation/Job Title: ____

Employment	City, State	Position	Dates

Emergency Contact (Name of Parent or Guardian is REQUIRED if the Applicant is a Minor)

Name: ____ Relationship: _______________

Address: ______________________________________ Home Ph. #: ________________

City: ___________________ State: ____ Zip: ________ Work Ph. #: ________________

Name: ______________________________

Educational Information

High School: ___________________________________ Graduation Date: ____________

Address: __________________ City: _______________ State:____ Zip: _______________

Trade, College, Graduate, and Professional Schools Attended

List in chronological order, **beginning with most recent.**

School	City, State	Dates	GPA	Major

Honors & Awards: ____

____

Extracurricular & Community Activities: _______________________________________

____

Licenses/Degrees Obtained: ____

Military Background: ____

Veterans' Benefits Status: ____________________________Date of Discharge_________

Personal Motivation

Why do you want to become a Massage Therapist? _______________________________

____

Have you ever had a massage and if so how did it make you feel? ____________________

____

If not, would you be willing to receive a massage prior to the start of school? __________

What are your Professional goals? ____

____

The training for Massage Therapist is very rigorous, are you prepared for the demands that will be expected of you? ______. Who are your support people? ______________________

OVER

Name: ________________________________

What are your expectations of the Institute of Therapeutic Massage? _________________

____

____

What are your reasons for choosing the Institute of Therapeutic Massage? _____________

____

____

How did you hear about the Institute of Therapeutic Massage? ______________________

Personal comments: ____

____

____

____

____

____

Census Data: Department of Education requires that we attempt to gather census data, you are not, however, required to provide it.

❑ Male ❑ Female ❑ African/American ❑ Caucasian ❑ Hispanic ❑ Other _________

Certain circumstances may adversely impact a student's ability to become licensed in the State of Ohio, even after successfully completing a massage therapy program. Such circumstances include, but are not limited to: having been convicted of committing a felony, illegal use of controlled substances, drugs or alcohol, or being diagnosed with bipolar, schizophrenia, paranoia or any other psychotic disorder. If a student has concerns as to how this may impact their education and subsequent licensure, please discuss this matter with the admissions staff.

Certification Statement

I certify that the information I have provided in this application is true and complete to the best of my knowledge. If accepted, any false or misrepresentation of information will be grounds for dismissal. I have read the Institute of Therapeutic Massage, Inc.'s catalog and understand the policies described there in.

Signature ____ Date ______________________

____ Date ______________________

Signature of Parent of Guardian if the Applicant is a Minor

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HEALTH CERTIFICATION FORM

This form does not require a Physical Examination, unless required by the Physician. A review of the applicant's medical records is adequate.

Applicant Name: ______________________________ Date of Birth: _______________

Address: _____________________ City: _____________ State: ____ Zip: __________

To be completed by a Physician only.

The above-named individual has applied to the Institute of Therapeutic Massage for consideration in enrollment. Students of Medical Massage come in touch contact with other students and clinical patients during their educational process. Students must be free of contagious diseases and have the physical capabilities to apply therapeutic techniques.

	Yes	No
Has the applicant ever had a serious injury or medical/mental illness?	___	___
Is the applicant now under the care of a physician or taking any medications?	___	___
Has the applicant ever blacked out or lost consciousness during physical activity?	___	___
Should there be any limitations placed on the applicant's participation?	___	___
Abnormal physical findings (including infectious or contagious diseases)?	___	___

If yes, please specify/recommendations.

____

Tuberculosis Skin Test. Date: ___________________ Results: _____________________

I certify that I have on this date examined the records of this applicant and that, on the basis of the examination and the applicant's medical history; I have found no reason which would make it medically inadvisable for this individual to participate in a course of study, both academic and practical, for Licensed Massage Therapist.

Physician's Name: _____________________________ Ph. #: _____________________

Address: _____________________City: ______________State: ____Zip:__________

Physician's Signature: ___________________________ Date: ______________________

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PERSONAL/PROFESSIONAL REFERENCE

Applicant Name: ____________________________________ Ph. #: _________________

Address: ________________________ City: ______________ State: ____ Zip: _________

The above-named individual has applied to the Institute of Therapeutic Massage for consideration in enrollment. Your reference on behalf of this prospective student will better enable us to determine his or her personal character and academic potential. All information provided will be kept confidential. Please return this form directly to the above school and address. Thank you.

In what capacity do you know the applicant?_____________________________________

How long have you known the applicant? _______________________________________

On a scale of 1 to 10, with 10 being excellent, rate the applicant as to…

Academic abilities _____
Ethical behavior _____
Application of knowledge _____
Task completion _____
Maturity _____
Integrity _____
Adapting to pressure _____
Social interaction _____

Personal comments: ____

____

____

____

Name: ______________________________ Date: _____________ Ph. #: _____________

Address: _________________________ City: ________________ State: ____ Zip:______

Signature: _________________________

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PO BOX 350
OTTAWA, OHIO 45875-0350

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Task completion _____
Maturity _____
Integrity _____
Adapting to pressure _____
Social interaction _____

Personal comments: ____

____

____

____

Name: ______________________________ Date: _____________ Ph. #: _____________

Address: _________________________ City: ________________ State: ____ Zip:______

Signature: ________________________

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REQUEST FOR HIGH SCHOOL TRANSCRIPT

INSTRUCTIONS TO APPLICANT: Complete the information below and take or mail it to your high school of graduation. Some schools may charge a fee. You may wish to check with your school prior to sending this form to them.

Name:____
Last First Middle Suffix (Jr. II)

Maiden Name:______________________________

Address:____
Street Address

____
City State Zip

Social Security Number:__________-________-___________

High School:____

Location:____
City State

❑ Graduated ❑ Will Graduate ❑ Withdrew Date:_________________________

I authorize my high school of graduation to release my transcript to the **Institute of Therapeutic Massage.**

____ ______________________
Signature of Applicant Date

INSTRUCTIONS TO HIGH SCHOOL: Upon receipt of this form, please forward a copy of an official transcript for the above named student to:

The Institute of Therapeutic Massage, Inc.
9508 SR 65
PO Box 350
Ottawa, OH 45875-0350

The transcript must include the following:

1. Total number of credit hours earned
2. Date of Graduation
3. Date of birth
4. Either the school seal or an original signature of a school official *(name stamps are not acceptable)*

If all of the information is not included the applicant will be requested to supply a new transcript. This will delay processing the applicant's request for a preliminary education number, which is required for enrollment in a Limited Branch School.