

AMTA Professional Member Application

Thanks for choosing AMTA to help you reach professional excellence. We're delighted to have you join us!

Member Contact Information

Name

Company

Address

City

State

Zip

Work Phone

Home Phone

Fax

E-mail

Website

Membership Confirmation

If you provide a current e-mail address above, we'll confirm your membership via e-mail.

PROFESSIONAL MEMBERSHIP

\$235 + _____ chapter fee = \$ _____

Please check and submit documentation for one of the following:

Photocopy of diploma or proof of graduation from a minimum 500 in-class hour entry-level massage therapy training program.

Photocopy of National Certification Board for Therapeutic Massage and Bodywork (NCBTMB) certificate or confirmation of passing score.

Photocopy of current AMTA-accepted city, state or provincial license.

Chapter Fees

AK \$25	DE \$25	KS \$30	MO \$15	NM \$25	SC \$20	WI \$30
AL \$20	FL \$20	KY \$25	MS \$15	NV \$20	SD \$17	WV \$20
AR \$5	GA \$30	LA \$15	MT \$20	NY \$20	TN \$15	WY \$15
AZ \$30	HI \$25	MA \$30	NC \$25	OH ¹ \$30/10	TX \$30	
CA \$25	IA \$10	MD \$30	ND \$0	OK \$30	UT \$30	
CO \$15	ID \$25	ME \$0	NE \$10	OR \$30	VA \$20	
CT \$20	IL \$30	MI \$20	NH \$30	PA \$20	VT \$20	
DC \$20	IN \$25	MN \$30	NJ \$20	RI \$20	WA \$30	

¹ OH: Professional Active \$30, Student \$10

CODE OF ETHICS AGREEMENT

I am familiar with the requirements of membership in the American Massage Therapy Association and agree to abide by the Bylaws and Code of Ethics upon acceptance of my membership. I understand that violation of the Bylaws or Code of Ethics can be grounds for termination of my membership. I attest that I have never had a permit or license related to massage therapy revoked, suspended or voluntarily surrendered. I am not currently under any disciplinary action on a complaint resolved or unresolved in this state or any other location.

I have read and agree to the above (signature)

Date

OPT-OUT OPTIONS

Mailing Lists

The AMTA membership list is occasionally made available to selected organizations and mailers of quality products. If you **do not** wish to receive such mailings, please check box at left.

E-mail Addresses

If you **do not** wish to receive e-mails from AMTA, please check box at left.

Fax Numbers

If you **do not** wish to receive faxes from AMTA, please check box at left.

PAYMENT OPTIONS

Check enclosed, payable to AMTA

Charge my MasterCard® Visa® Discover®

Card Number

Expiration Date

Cardholder's Name

Cardholder's Zip Code

Cardholder's Signature

AMTA is not responsible for fees resulting from bounced checks, stop-payments, overdrawn accounts or exceeded credit limits. Dues are nonrefundable.

MAIL OR FAX YOUR COMPLETED APPLICATION TO:



AMTA Member Services
500 Davis Street, Suite 900
Evanston, IL 60201-4695
Fax: 1-847-864-5196

Thanks for joining our family of massage therapists!

AMTA Professional Member Application

AMTA'S FIND A MESSAGE THERAPIST® NATIONAL LOCATOR SERVICE

By completing the following I am agreeing to be a part of AMTA's Find a Massage Therapist national locator service. Once enrolled, I understand I'll be listed in the online national locator service and with the toll-free number, 1-888-THE-AMTA (843-2682).

Fill in all of the following ONLY if you'd like a different contact listed for your national locator service address than the contact address that you previously listed.

Yes, I would like different contact information for my national locator service listing.

*Required Fields

Address _____

City _____ State _____ Zip _____

Telephone* _____ Fax _____

E-mail* _____

Website _____

I *do not* want my e-mail address to appear online.

State License/Certificate No. (if applicable) _____

Certified by: NCBTMB NCCAOM

1. What are your usual office/practice hours?

(check all that apply)

	Mornings	Afternoons	Evenings
Monday	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tuesday	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wednesday	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thursday	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Friday	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Saturday	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sunday	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. Which types of clients will you accept? (check all that apply)

Male Only Female Only Infants Children All

3. What is your gender? Male Female

4. I accept medical insurance Yes No

5. I sell gift certificates Yes No

6. At which of the following sites do you practice?

(check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Chiropractic Office | <input type="checkbox"/> Nursing Home/Hospice |
| <input type="checkbox"/> Client's House | <input type="checkbox"/> Private Practice |
| <input type="checkbox"/> Client's Office | <input type="checkbox"/> Rehab Center |
| <input type="checkbox"/> Day Spa | <input type="checkbox"/> Resort |
| <input type="checkbox"/> Health Club/Fitness Center | <input type="checkbox"/> Salon |
| <input type="checkbox"/> Hospital | <input type="checkbox"/> Therapist's Home Office |
| <input type="checkbox"/> Massage Office | <input type="checkbox"/> Wellness Center |
| <input type="checkbox"/> Medical Office | |

7. Which are you trained in, competent in and practice most often? (check up to 7 items)

- | | |
|---|---|
| <input type="checkbox"/> Acupressure | <input type="checkbox"/> Pregnancy Massage |
| <input type="checkbox"/> CranioSacral TherapysM | <input type="checkbox"/> Pressure Point Therapy |
| <input type="checkbox"/> Deep Tissue Massage | <input type="checkbox"/> Reflexology |
| <input type="checkbox"/> Energy Work | <input type="checkbox"/> Reiki |
| <input type="checkbox"/> Geriatric Massage | <input type="checkbox"/> Russian Massage |
| <input type="checkbox"/> Infant Massage | <input type="checkbox"/> Shiatsu |
| <input type="checkbox"/> Lomi Lomi | <input type="checkbox"/> Somatic Movement SM |
| <input type="checkbox"/> Lymphatic Drainage | <input type="checkbox"/> Sports Massage |
| <input type="checkbox"/> Movement Education | <input type="checkbox"/> Stone Therapy |
| <input type="checkbox"/> Neuromuscular | <input type="checkbox"/> Structural Integration |
| <input type="checkbox"/> On-site Chair Massage | <input type="checkbox"/> Swedish Massage |
| <input type="checkbox"/> Oriental Bodywork | <input type="checkbox"/> Thai Massage |
| <input type="checkbox"/> Polarity Therapy | <input type="checkbox"/> Trigger Point Therapy |

The following are registered marks and can only be used if you're authorized by the organization that controls the mark. Please check with the organization if you're unsure.

- | | |
|--|---|
| <input type="checkbox"/> Feldenkrais Method® | <input type="checkbox"/> Rolfing® |
| <input type="checkbox"/> Myofascial Release® | <input type="checkbox"/> Trager® Approach |
| <input type="checkbox"/> Myotherapy® | <input type="checkbox"/> Zero Balancing® |

8. Indicate your non-massage education

(check all that apply)

- Junior College 4-Year College
- Master's Degree Ph.D. Other

9. How many years have you been a practicing massage therapist?

0-2 3-4 5-7 8-10 11-15 16-20 21+

10. I agree to abide by AMTA's Code of Ethics

Yes No