



M.T. Wellness Masters Center

**OFFICE OF ADMISSIONS**

1151 Bethel Rd, Suite 303

Columbus, OH 43220-2775

[www.MTWellnessClinic.com](http://www.MTWellnessClinic.com)

Phone: 614-273-0810 Email: [Info@MTWellnessClinic.com](mailto: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 / \_\_\_\_\_
- ✓ Current Resume and List of Continuing Education/ \_\_\_\_\_
- ✓ Copy of current pocket-card of unrestricted Ohio license as Massage Therapist (OH LMT) and copy of Limited Practitioner's Certificate from State of Ohio Medical Board \_\_\_\_\_
- ✓ 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 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 / \_\_\_\_\_

**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 list of Continuing Education.

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 7 8

High School

Name & Location	From	To	Diploma	GPA	Extracurricular Activities

Continued

**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 hereby attest that all information provided in this application is true and accurate. I understand that if 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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**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 a Massage Therapy program with the intention of qualifying for their Masters Certificate in Medical Restorative Massage Therapy © (CRMT). The program 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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**Request for Massage Therapy School Transcripts**

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

Name of Intern 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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**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 © (CRMT). 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 a 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):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Physician's Signature \_\_\_\_\_ Printed Name \_\_\_\_\_

Address \_\_\_\_\_

Phone (\_\_\_\_)- \_\_\_\_ - \_\_\_\_\_

Fax (\_\_\_\_)- \_\_\_\_ - \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**Please return immediately via mail to:**

M.T. Wellness Masters Center  
1151 Bethel Road, Suite 303  
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