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APPLICATION FOR ADMISSION

(Please print or type)

The following requirements are necessary for applicants requesting admission to the 750-hour Massage Therapy Program:

To be considered for admission, applicants must:

1. Be at least 18 years of age;
2. Be a high school graduate or have a GED;
3. Submit a completed application packet;
4. Be physically, mentally and psychologically able to participate in massage therapy training and profession; and
5. Participate in an admissions interview with an Admissions Advisor.

To be considered for admission, applicants must submit:

1. A completed and signed application form;
2. A completed and signed health evaluation form;
3. A current photo; and
4. Two letters of recommendation *or* character references. If submitting character references, information must be completed on page two of this application. Recommendation letters must:
 - a. Be written and signed by individuals other than relatives, and include name, address and telephone number of respondent; and
 - b. Address the following two questions: How do you know the applicant? Do you feel s/he has the qualities of character and integrity to be a professional health care practitioner?

Name: _____ Gender: F M
Last First Middle Preferred

Home Address: _____
(Current) Street City State Zip

Phone: Day (____) _____ Evening (____) _____ SS#: _____ - _____ - _____

Email Address: _____ Birthdate: ____/____/____

In case of emergency, contact: _____ Relationship: _____

Emergency Contact's Phone: Day (____) _____ Evening (____) _____

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Character References: (Do not list relatives. This section must be filled out completely.)

1. Name _____ Relationship _____

Address _____

Phone (day) _____ (eve) _____

2. Name _____ Relationship _____

Address _____

Phone (day) _____ (eve) _____

1. Are you currently a professional massage therapist?

YES NO If yes, briefly describe the focus of your work:

2. Describe briefly any previous massage/bodywork experience you have had including any professional treatments or sessions received, workshops professional programs or trainings:

3. Education history (include high school, college, etc.)

School	Dates	Area of Study	Results
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

4. How did you first find out about the MTTI-WellSpring?

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5. Current Occupation: _____ Full-time Part-time

Current work hours: _____

Employer: _____ Phone (_____) _____

6. Briefly describe your work history:

7. Have you ever been charged or convicted of a crime, including any misdemeanors or felonies?
If yes, please provide complete details, including date, nature of offense and resolution.

YES NO

[MTTI is required to obtain written disclosure of criminal history from all applicants. This written disclosure, in conjunction with federal and state level background checks, will be reviewed by the Missouri Board of Therapeutic Massage prior to issuing a student license and professional license.]

(Use additional sheets if necessary)

8. Briefly describe the following: (Use additional sheets if necessary)

a. Why you want to attend MTTI-WellSpring

b. Why you want to become a massage therapist:

9. What strengths and challenges do you perceive you will bring to your educational process:

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MTTI-WELLSPRING HEALTH EVALUATION

In the interest of your success, it is important that we assess your physical and psychological wellness status to determine whether there are any problems that would prevent you from fulfilling the requirements of this program. If contraindications exist, we will contact you for further discussion and/or recommendation.

This health evaluation will remain confidential and becomes part of your permanent student record. Please print and answer **all** questions. If the question is not applicable, please indicate so.

Name _____ Age _____ Hgt. _____ Wgt. _____

1. Name and phone number of primary health care provider: _____

2. List all medication(s) taken regularly (include herbs, aspirin, etc.) and **describe the purposes for which they are taken:**

3. Do you have any physical limitations? yes no Please describe: _____

4. Do you have a learning disability? yes no Please describe: _____

5. Are you presently receiving treatment for any reason? yes no
Include counseling, alternative health care, substance abuse programs such as AA, etc. Please provide the name of the health advisor/counselor and phone number:

6. Have you ever been treated for mental or emotional disorders? yes no Please explain:

7. Describe injuries incurred due to accidents or sports: _____

8. Please check all conditions that apply to you. **Please indicate present or past history.** If past history, please indicate the year:

- | | |
|--|--|
| <input type="checkbox"/> AIDS/ARC/HIV | <input type="checkbox"/> Fainting/Blackouts |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Gallbladder Trouble |
| <input type="checkbox"/> Allergies That Restrict Normal Activity | <input type="checkbox"/> Frequent Headaches |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Migraine Headaches |
| <input type="checkbox"/> Back Problems That Restrict Normal Activity | <input type="checkbox"/> Hepatitis/Jaundice |
| <input type="checkbox"/> Blood Clots/Blood Clotting | <input type="checkbox"/> Hearing Loss |
| <input type="checkbox"/> Extremely High/Low Blood Pressure | <input type="checkbox"/> Hernia/Rupture |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Joint Disease/Injury |
| <input type="checkbox"/> Serious Circulatory Problems | <input type="checkbox"/> Mental/Emotional Disorders |
| <input type="checkbox"/> Chronic Fatigue Syndrome | <input type="checkbox"/> Mononucleosis |
| <input type="checkbox"/> Convulsions/Seizures | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Insulin Dependent Diabetes | <input type="checkbox"/> Skin Problems (Ulcers/Chronic Rashes) |
| <input type="checkbox"/> Clinical Depression | <input type="checkbox"/> Extreme Lack of Stamina |
| <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Severe Varicose Veins |

9. Describe any other illness, injuries or surgeries that restrict normal activity (include date):

I hereby certify that the above history is complete to the best of my knowledge. I grant MTTI-WellSpring permission to contact the Primary Health Care Provider listed above in order to verify or further evaluate the answers herein this health evaluation.

Applicant's Signature

Date