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AMERICAN MEDICAL MASSAGE NETWORK (AMMN)

41800 Hayes Road, Suite 116, Clinton Township, MI 48038

https://www.americanmedicalmassage.org - info@medicalmassagenetwork.org

Application for Membership/Affiliation

Full Name:_____ ☐ Female ☐ Male ☐_____

. Last First Middle

Date of Birth: _____ (Age_____) Place of Birth_____ Social Security #_____

Languages you speak – besides English: ☐_____ ☐_____ ☐_____

Current Home Address: _____Tel:_____

Where do you work ☐ At Home ☐ My Clinic ☐ Franchised Clinic ☐ Spa ☐ _____ ☐ _____

Name of Clinic/Organization: _____Tel:_____

Clinic Address: _____Supervisor:_____

Cell Tel: _____Email_____Website:_____

Emergency Contact-1_____Tel:_____Email_____

Emergency Contact-2_____Tel_____Email_____

☐ Licensed as a Massage Therapist in_____ License No._____ Expiry date: _____

☐ Licensed as a Massage Therapist in_____ License No._____ Expiry date: _____

☐ Licensed Since: _____ Any Other License: ☐ Yes ☐ No _____

EDUCATIONAL INFORMATION:

	Name of School	Location	Dates attended (from/to)	Certificate/Diploma
High School:	_____	_____	_____	_____
College/University:	_____	_____	_____	_____
Massage School:	_____	_____	_____	_____
Other:	_____	_____	_____	_____

- **Practical Training/Experience (including CME/CE or Specialization Courses in Massage, Healthcare or other. Kindly list in chronological order.**

	Name of Organization	Subject/Field	Dates (from/to)	Duration	Certificate/Diploma
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____
5.	_____	_____	_____	_____	_____
6.	_____	_____	_____	_____	_____
7.	_____	_____	_____	_____	_____

8. _____ _____ _____ _____ _____

- **Practical Training/Experience (including CME/CE or Specialization Courses in Massage, Healthcare or other. Kindly list in chronological order.**

	Name of Organization	Subject/Field	Dates (from/to)	Duration	Certificate/Diploma
9.	_____	_____	_____	_____	_____
10.	_____	_____	_____	_____	_____
11.	_____	_____	_____	_____	_____
12.	_____	_____	_____	_____	_____
13.	_____	_____	_____	_____	_____
14.	_____	_____	_____	_____	_____
15.	_____	_____	_____	_____	_____

- **Any other Job, experience or training? Kindly list in chronological order.**

	Name of Organization	Subject/Field	Your Function	Dates (from/to)	Duration
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____

Memberships: ☐AMTA ☐ABMP ☐NCBTMB ☐_____ ☐_____ ☐_____ ☐_____

☐Have you ever been convicted of a felony or have had any criminal record. ☐No ☐Yes _____
☐Have you had any Ethics Problem or Malpractice Lawsuit? ☐No ☐Yes _____
☐Have you had Massage Therapy or any other license suspended or cancelled ☐No ☐Yes _____
☐ ***Based on my academic & practical training, experience, and competencies, I have done self-evaluation and feel that I am qualified to be placed in*** ☐ ***Level-1*** ☐ ***Level-2*** ☐ ***Level-3 of Specialization as a Medical Massage Specialist in*** _____.

☐ I am attaching herewith my ☐resume ☐copies of my license(s) ☐copies of my credentials, and ☐photo, as required.

I confirm that the above information is true and correct to the best of my knowledge. I understand that any misrepresentation or false information may result in denial of this application or dismissal from AMMN at any time. I have read & agree with the criteria for membership/affiliation with the American Massage Therapy Network, and I agree with the current and future rules & regulations, including fee structure & operational policies of AMMN.

I have done my self-evaluation for being a Specialist in certain therapeutic massage modalities, but I authorize AMMN to do its own professional evaluation and assign me to the Level of Specialization, AMMN feels as appropriate, based on my education, training & competence. I agree that I do not have the right to appeal that decision, but once I have done additional training, and have made an application of re-evaluation & paid the applicable fee, that my Level of Specialization may be changed. I agree to keep AMMN informed of any change in my license, location, ownership, etc.

I agree that my typed name below represents my signature.

Signature: _____ **Date:**_____

- ***Membership is for individual therapists. If you have other partners or employees, each person must submit their own application and submit their credentials & photo separately, in order to independently qualify for their own personal membership/affiliation and receive referrals from AMMN, based on their own level of specialization. .***

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