

INSTITUTE FOR THERAPEUTIC MASSAGE

MORRISTOWN MEMORIAL HOSPITAL – HOSPITAL BASED PROGRAM

APPLICATION FOR ADMISSION

READ: It is extremely important that applicants follow the directions in filling out and submitting the school Application for Admission as soon as possible to ensure a place in class. Incomplete applications will be returned to the applicant for further information - this may result in a delay when processing the application.

Personal Assistance with Application

We want the process of applying to the program to be as easy as possible. If at any time you have questions or need additional assistance with the application, please contact the Pompton Lakes Location:

125 Wanaque Avenue . Pompton Lakes, NJ . 07442
tel. 973-839-6131 fax. 973-839-9878



Joanne Braun, LMT, ITM Instructor massaging a hospital volunteer as Jason Alviene, NCTMB comforts an infant of the Boarder Baby Unit at UMDNJ-Newark.

“There are many ways we try to satisfy our need for comfort when all we really need is to be touched.”

- *Massage Therapy Journal, Winter 2004*

What you need to do:

Complete the application form in its entirety and submit application with your \$25.00 non-refundable application fee. **Please submit application in a timely manner to reserve your spot - supporting documents can follow.**

Submit a copy of your current insurance membership card and certificate of insurance.

Submit a copy of your certificate, diploma or state license from a state-approved school of massage.

Submit medical paperwork verifying the result of your physical exam, including a negative Mantoux result within last six months. If there is a positive Mantoux history, a chest x-ray result must be negative for TB.

The school contract will be sent to you upon receipt of your application - a \$100.00 non-refundable registration fee is required with the submission of your contract to secure your place in class.

1. Choose your payment plan:

Sallie Mae Educational Loan

Submitted to school

Submitted on-line

3-Month

2. Personal information:

Full Name		
Address (Street & PO Box if applicable)		
City/Town	State	Zip Code
County	Home Phone	Cell or Alt. Phone

3. Educational Background:

High School	Date Attended	Year Graduated
College/University	Date Attended	Year Graduated
Massage Education	Date Attended	Year Graduated/Total Hours
GED Certification	Date Attended	Date Taken/Rec'd

4. Statistical Information: Please note that the following information is for the United States and New Jersey Department of Education statistics ONLY and that this application is confidential. The school does not discriminate based on age, gender, race, ethnic origin, religion, sexual orientation or disability.

Social Security Number:	Gender (please circle): Male / Female	
Date of Birth:	Current Age:	Are you officially classified as disabled? (please circle): Yes / No
Race or Ethnicity (please check): <input type="checkbox"/> white/non-hispanic <input type="checkbox"/> black/non-hispanic <input type="checkbox"/> hispanic <input type="checkbox"/> american indian/alaskan native <input type="checkbox"/> asian <input type="checkbox"/> native hawaiian/pacific islander <input type="checkbox"/> multi-racial <input type="checkbox"/> unknown	Highest level of education at enrollment (please check): <input type="checkbox"/> less than high school graduate <input type="checkbox"/> high school graduate <input type="checkbox"/> some college or technical school <input type="checkbox"/> associate degree <input type="checkbox"/> bachelor's degree <input type="checkbox"/> graduate degree	Employment status at enrollment (please check): <input type="checkbox"/> employed, full time <input type="checkbox"/> employed, part time <input type="checkbox"/> not employed <input type="checkbox"/> unknown

5. Employment Information:

Company	Work Phone
Full Address	
<input type="checkbox"/> Please check this box if you do NOT want to be contacted at work for ANY reason.	

6. Health (check all that apply):

- High Blood Pressure
 - Joint Swelling
 - Epilepsy
 - Osteoporosis
 - Diabetes
 - Varicose Veins
 - Chronic Back Pain
 - Arthritis
- Have you had any broken bones? _____
- Do you experience any numbness or tingling? _____
- Do you experience stabbing pains? _____
- Do you have any circulatory problems? _____
- Do you suffer from any allergies? _____
- Are you pregnant? If so, how many months? _____
- NONE OF THE ABOVE

Are you under care for any other physical or mental condition? Please describe (all information is confidential).

To insure your success during your education, please let us know about any challenges in learning comprehension or study skills:

Why do you want to be a part of Hospital Based Massage?

Why did you choose this school?

How did you find out about us?

- Internet
- Phone
- Advertisement
- Student or Graduate - Their
- Other? _____

7. Signature:

By signing below, you are attesting that all information provided herein is accurate and truthful to the best of your knowledge. Any falsification or withholding of pertinent information may result in rejection of application or dismissal from the program. Please note that class is limited in size and submission of this application does not guarantee admission. The Institute for Therapeutic Massage, Inc. admits qualified students regardless of race, religion, national origin, gender, age, sexual orientation or marital status.

Student Signature: _____ Date: _____

Emergency contact: _____ Phone: _____