

Initial Application for the National Board Certification Agency Continuing Education Providers

Individuals, Schools, and Organizations completing this application should already be offering programs for massage therapist and/or body-workers which meet the NBCA criteria. Continued Education programs are to have been presented two (2) times in the past two years prior to completion of this application

****Type or legibly print this page only. All other materials must be typed.****

Date: _____

Name of School/Provider: _____

Address: _____

City: _____ State: _____ Zip Code: _____ Country: _____

Phone: (_____) _____ Fax: (_____) _____

e-mail: _____

Individual responsible for completing this application:

Name: _____ Title: _____

Phone: (_____) _____ Fax: (_____) _____

Indicate Status of CEU Provider: Individual - \$100 Fee (only one person)
 Organization - \$250 (More than one person, an Association, a Chapter of an Association, an Agency, Corporation, etc.)

CREDIT CARD INFORMATION FOR VISA / MASTERCARD

Check enclosed Credit Card: Visa MasterCard Discover American Express

Name on Card: _____

Authorized Signature: _____ Total Amount Charged: \$ _____

Address: _____

Credit Card Number: _____ Expiration Date: _____ Security Code: _____

CRITERION I. ADMINISTRATION:

Applying as an:

- 1.1 Individual Organization School

Section 1. If Applicable: *Attach a copy* of each current license, approval, and/or accreditation earned by the Program, Organization, or School.
(Do not include organizational memberships, certifications, or school diplomas)

If Not Applicable, Please proceed to Section 2 and complete required information.

A: The Program, School, College, or University is accredited by (please ✓ all that apply)

_____ ACCET (Accreditation Council for Continuing Education and Training)

_____ ACCSCT (Accreditation Commission for Career Schools and Colleges of Technology
CCA and NATTS)

_____ COMTA (Commission on Massage Training Accreditation)

_____ Regional accreditation agency approved by the US Department of Education

Agency Name: _____

_____ Other Accrediting Agency(s): _____

Date initially accredited by the above listed agency(s): _____

Section 2: If Section 1 is not applicable, you are to complete this section

B. Please provide a written explanation of your program(s) including how long the organization or school has been providing courses, average class size, number of times course/class has been presented, type of facilities, number of faculty (full and part-time), and a copy of the school catalog and/or course description if applicable.

C. Has a sanction been imposed on you/the organization by a licensing or credentialing body?

_____ No

_____ Yes. If so, please state what the sanction was for, when it was imposed, by whom, and what your current status is.

1.2 Provide the rationale/justification for the scope of continuing professional education or school curriculum you would like approved. Explain how participation in the course(s) will increase skills and knowledge of the massage therapist/body-worker.

1.3 Are programs jointly sponsored with another agency, school, organization or individual?

_____ No

_____ Yes. Attach written Co-Provider Agreement Form (see page 9) and list the name and address of the co-provider below.

Name of co-provider: _____

Address: _____

1.4 List the courses or programs you wish to provide and the type of certificate that will be awarded. Attach a sample Certificate of Completion or Certificate of Achievement (whichever you use). Each certificate must include name of the school or CE provider, continuing education hours or CEU's issued (refer to definition of CEU), date of completion, name of course and the participant's name. If you are a school seeking program or course approval, attach a copy of the student Transcripts issued for your program or course.

CRITERION 2. CURRICULUM CONTENT:

2.1 Identify the purpose and goal of the educational program, which includes defining the target audience for each specific educational offering.

2.2 Describe how content is identified to assure it is current and relevant to the profession.

2.3 Describe how relevant research and theories are incorporated into the various educational offerings.

2.4 Is this a self-paced or home study learning activity?

_____ No

_____ Yes. If so, submit the following information in narrative form:

Rationale for using self-paced learning:

- a. Course and instructional outcomes
- b. Unit objectives
- c. Content materials
- d. Testing process
- e. Completed participation evaluation form of the course
- f. Time allowed to complete program

2.5 Is this distance learning opportunity?

_____ No

_____ Yes. If so, submit the following information in narrative form:

- a. Available support and resources for this approach
- b. Feedback is given to certificates regarding process
- c. Testing process

CRITERION 3. INSTRUCTOR QUALIFICATIONS:

3.1 Describe how individuals are determined to be qualified in the design, planning, implementation, administration, and delivery of each course.

3.2 Describe how instructors are evaluated and attach a sample Course/Instructor Evaluation Form.

CODE OF CONDUCT AGREEMENT

As an applicant for approval, I/our organization agree(s) to:

1. Provide accurate information to the NBCA in all transactions to the best of our knowledge.
2. Assure that course credits are awarded only to participants who successfully complete the course according to the published requirements.
3. Conduct the operations and programs in an ethical manner that respects the rights and worth of the clients we serve.
4. Use and display the provider statement and logo according to the NBCA requirements.
5. Furnish requested information; work cooperatively with the NBCA, and pay fees in a timely manner.
6. Accept the NBCA designated monitors without fees in any courses we provide for purposes of monitoring compliance with the criteria.
7. After due review and comment period, abide by any revisions of the criteria or inform the NBCA of any intention to withdraw provider ship.
8. Maintain compliance with the NBCA Standards of Practice, Code of Ethics, and policies and procedures.
9. Adhere to the NBCA criteria/standards or relinquish the NBCA approval status after due process.
10. Report to the NBCA any major organizational or program changes within thirty (30) days that impact the operation of the administrative unity on which provider approval is based.

Provider _____ hereby agree with all of the foregoing terms and conditions.

Signature: Chief Administrative Officer

Title

Print/Type Name

Print/Type Title

Date: _____

Detach, Sign and Return with Application

BIOGRAPHICAL FORM

CHECK ALL THAT APPLY:

_____ Administrator _____ Faculty _____ Teaching Assistant

Instructions: Make as many photocopies of this form as necessary to provide documentation of an individual's expertise. Information must be typed or legibly printed directly on a copy of this form. **Do Not attach any additional material as curriculum vitae, promotional/marketing materials, etc.**

Name and Degrees: _____

Preferred Mailing Address: _____

Telephone (_____) _____ - _____ Fax: (_____) _____ - _____

E-mail _____

Present Position (Employer, title and description) _____

Education (include basic preparation through highest degree held):

| INSTITUTION (NAME, CITY/STATE) | MAJOR AREA OF STUDY | DEGREE/DIPLOMA/CERTIFICATION(S) YEAR AWARDED |
|--------------------------------|---------------------|--|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Use the space below and an additional page if necessary to briefly describe your professional experience or areas of expertise (including publications) related to your involvement in schooling or continuing professional education in massage therapy and/or body-work. Note your particular role, i.e., planner, presenter, administrator, etc.

PROGRAM/COURSE DESCRIPTION and CONTINUING PROFESSIONAL EDUCATION FORM

Title of Program/Course: _____

Number of Continuing Professional Education Hours: _____

Total Number of Program Hours: _____

Dates Program/Course has been offered: _____

Course Description: Fully describe the program/course using measurable outcomes; i.e. students will be able to demonstrate, show, explain, list, etc. Please note: programs/courses need to have been presented two (2) times within the past two (2) years.

| | |
|---|--|
| <p>Learning Outcomes: List the Outcomes in measurable terms which are attainable and can be evaluated as relevant to the practice of massage therapy and/or body-work.</p> | |
| <p>Program Content/Time Frame: List program content and Time Frame with Learning Outcomes/Objectives reflected in the schedule.</p> | |
| <p>Presenter(s): List the presenter(s) for each topic, section, or content area.</p> | |
| <p>Teaching Strategies: List the teaching strategies employed by all presenters.</p> | |
| <p>Learning Environment: Describe the professional learning environment used for this Program/Course.</p> | |

*Please attach additional forms as necessary for each program/course seeking approval.

PROVIDER AGREEMENT

Please use this form if you are offering a Program or Continuing Education course with another NBCA approved provider. This form is to be filled out jointly by the Approved Provider and the institution/organization/individual co-hosting this program or course.

If the Secondary Provider is not already an AMMA approved school or NBCA approved provider, please attach to this page the information contained in sections **1.1** and **1.2**, the **Biographical Form(s)** and the **Program/Course Description Form(s)**.

Primary NBCA Member Approved Provider:

Name: _____ Date: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Signature of Authorized Representative: _____

Secondary Non-Approved Provider:

Name: _____ Date: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Signature of Authorized Representative: _____

Please check the appropriate box for the provider who will be responsible for initializing and maintaining the following information:

Certificates of Completion or Achievement:

Primary Provider Secondary Provider

Course/Instructor Evaluations:

Primary Provider Secondary Provider

Transcripts:

Primary Provider Secondary Provider

Marketing, Promotion and Venue:

Primary Provider Secondary Provider

*If any of the above are shared responsibilities, please indicate which provider will maintain the original paperwork. Evaluations and Transcripts must be saved for a minimum of four (4) years. Your signature above will serve to confirm the provider responsible for maintaining all applicable information.