



application for admission

Please complete and mail to:
Sarasota School of Massage Therapy
5899 Whitfield Ave, Suite 302
Sarasota, FL 34243

Phone: (941) 957-0577

Please indicate a start date and schedule:

- August 4, 2010 - 5 Days per week
 September 14, 2010 - 3 Nights per week

Name _____

Address _____

City _____ State _____ Zip _____

Phone (H) _____ (W) _____

E-mail Address _____

Social Security # _____

Sex: M F Birthdate ____ / ____ / ____

Notify in case of Emergency _____ Phone _____

Address _____

City, State, Zip _____ Relationship _____

Have you ever been convicted of a crime? Yes No
If so, please explain _____

Please provide two references

1. Name _____ 2. Name _____

Address _____ Address _____

Phone _____ Phone _____

Relationship _____ Relationship _____

How did you find out about Sarasota School of Massage Therapy? _____

How will your tuition be paid? Self Parent Federal Aid VA Other

Please use the back of this page to briefly tell us about yourself and why you would like to pursue your education at the school. List any previous massage therapy or health care experience you may have. State the reasons you have decided on Massage Therapy as your profession, and why you feel you are suited to the profession. (Take as much or as little space as you like.)

I certify that the information above is true and I give SSMT permission to run a background check. I understand that it will be held in confidence and will be used to determine the degree to which I may benefit from this training.

Signature _____ Date _____