

**Initial Application for the American Health Source  
American Medical Massage Association:  
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 AMMA 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.)

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**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 AMMA 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 AMMA requirements.
5. Furnish requested information; work cooperatively with the AMMA, and pay fees in a timely manner.
6. Accept the AMMA 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 AMMA of any intention to withdraw provider ship.
8. Maintain compliance with the AMMA Standards of Practice, Code of Ethics, and policies and procedures.
9. Adhere to the AMMA criteria/standards or relinquish the AMMA approval status after due process.
10. Report to the AMMA 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><b>Learning Outcomes:</b> 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><b>Program Content/Time Frame:</b> List program content and Time Frame with Learning Outcomes/Objectives reflected in the schedule.</p>	
<p><b>Presenter(s):</b> List the presenter(s) for each topic, section, or content area.</p>	
<p><b>Teaching Strategies:</b> List the teaching strategies employed by all presenters.</p>	
<p><b>Learning Environment:</b> Describe the professional learning environment used for this Program/Course.</p>	

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

## CO-PROVIDER AGREEMENT

Please use this form if you are offering a Program or Continuing Education course with another AMMA 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/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)**.

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### Primary AMMA Member Approved Provider:

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Signature of Authorized Representative: \_\_\_\_\_

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### Secondary Non-Approved Provider:

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Signature of Authorized Representative: \_\_\_\_\_

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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

#### Transcripts:

Primary Provider  Secondary Provider

#### Course/Instructor Evaluations:

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.