



# application for admission

*Please complete and mail to:*  
Sarasota School of Massage Therapy  
5899 Whitfield Ave, Suite 300  
Sarasota, FL 34243

Phone: (941) 957-0577

*Please indicate a start date and schedule:*

- June 11, 2012 - 5 Days per week  
 July 17, 2012 - 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

*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 \_\_\_\_\_