

SHENANDOAH VALLEY SCHOOL OF THERAPEUTIC MASSAGE, LLC

215 Piccadilly Street, Edinburg, Virginia 22824

540-984-9629 or 888-836-0400

Application for Admission

Please print

Name: _____ Date: _____

Street Address: _____

Mailing Address: _____ Birth date: _____

City: _____

State, Zip: _____ Soc. Sec. # _____

Home phone: _____ Work phone: _____

Occupation: _____ Gender: Male Female

US Citizen: Yes No

Emergency contact: _____ Phone: _____

High School Name: _____
(Or GED)

City, State: _____

Date Diploma or GED received: _____ ****Please provide copy.**

College attended: _____

City, State: _____

Highest degree received: _____ Date received: _____

Have you ever had a professional massage? Yes No

Mail this application to: **Shenandoah Valley School of Therapeutic Massage, LLC**
215 Piccadilly Street, Edinburg, Virginia 22824

Please write a statement explaining your interest in massage therapy and how you intend to use your training in massage.

Please enclose a check for \$100.00 for enrollment processing made out to SVSTM. This school maintains and promotes equal employment and educational opportunity without regard to race, color, gender, age, religion, disability, national origin or other non-merit factors.

How did you learn about the school? _____

I certify that the above statements are true and correct to the best of my knowledge. I will abide by the rules and regulations of the school. I understand that if I do not provide my social security number or individual taxpayer identification number, the school will not be able to report information for my educational tax credits to the IRS.

Signature: _____ Date: _____

SHENANDOAH VALLEY SCHOOL OF THERAPEUTIC MASSAGE, LLC

215 Piccadilly Street, Edinburg, Virginia 22824

540-984-9629 or 888-836-0400

(Two references required)

Personal Reference Form

Name of Applicant: _____

Name of Reference: _____

This applicant has applied to attend our 630-hour professional massage therapy program. We seek your thoughtful evaluation of this applicant's ability to successfully complete this program. We appreciate the time you will spend completing this form.

1. How long have you known this person?
2. What is your relationship with this person? (Friend, business, professional, neighbor, etc.)
3. How would you rate this applicant's integrity and dependability?
4. Does he/she get along well with other people?
5. How would you describe this person's communication skills?
6. How would you describe this person's academic abilities?
7. Please state why you **would** or **would not** recommend this person for massage therapy training.
8. Additional comments (please use the reverse side if needed).

Your signature _____ Date _____

Address _____

Telephone _____ Fax number _____

Please send to: Shenandoah Valley School of Therapeutic Massage, LLC
Attention: Admissions
215 Piccadilly Street, Edinburg, Virginia 22824

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Attention: Admissions

215 Piccadilly Street, Edinburg, Virginia 22824

SHENANDOAH VALLEY SCHOOL OF THERAPEUTIC MASSAGE, LLC
215 Piccadilly Street, Edinburg, Virginia 22824
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Professional Therapeutic Massage Program Enrollment Agreement

I, _____, acknowledge that I am enrolling in the Professional Therapeutic Massage Program at Shenandoah Valley School of Therapeutic Massage, LLC, 215 Piccadilly Street, Edinburg, VA 22824, a 630-hour program which will take approximately 10 months to complete full-time, or 16 or 20 months to complete part-time, should I continue straight through the program.

Non-refundable enrollment fee:	\$ 100.00
Books and supplies:	\$ 450.00
Tuition:	<u>\$8,020.00</u>
Total:	\$8,570.00

I understand that I may cancel this agreement or I may withdraw from this program at any time by sending the school a written statement of cancellation or withdrawal. The address above is the one to use in all correspondence. I understand this agreement becomes a legally binding instrument when I have been accepted into the school, and I have submitted this agreement with **the \$100 enrollment fee and \$450 tuition deposit.**

I also can choose to pay monthly installments at 5% interest at a total of \$8,420.00 (less the enrollment fee and tuition deposit) equal to monthly payments of \$527.00 over 16 months of class (for the online part-time classes), or \$421 per month (for the inclass part-time classes) over 20 months or \$842.00 per month (for the full time program) for 10 months. I elect to pay monthly installments_____.

By electing to pay monthly installments, I agree to provide SVSTM with a current credit report of my financial status as part of the admissions process.

If I elect to cancel this agreement or withdraw from this program, I understand that the following refund schedule, as outlined in the school catalog, will be used to determine the refund due me:

Enrollment fee of \$100 is non-refundable.

If I withdraw prior to the fourth business day after enrolling in the program, the full tuition deposit is refundable. If I withdraw on the fourth business day but before classes begin, \$100 of the tuition deposit is non-refundable. Any tuition on deposit greater than \$100 is refundable. If I withdraw or am terminated during the program, the remaining percentage of the program's tuition which has been paid is refundable.

Student signature:_____ Date:_____

Neva Clayton, Director_____ Date:_____

SHENANDOAH VALLEY SCHOOL OF THERAPEUTIC MASSAGE, LLC

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Physician Certification Form

Please print

Name: _____ Date: _____

Address: _____ Birth date: _____

City: _____

State, Zip: _____ Soc. Sec. #: _____

Home phone: _____ Work phone: _____

I hereby certify that the individual named above has been found free of any skin condition, contagious diseases or any other identifiable conditions that could cause him/her to be a hazard in the provision of his or her services as a massage therapist.

In addition, I have found the above individual to be free from communicable tuberculosis through the evidence of one of the following (check one):

A negative tuberculin skin test (PPD) administered on _____ and read on _____.

A chest x-ray indicating no evidence of active pulmonary disease administered on _____.

Date: _____

Physician's signature

Please print

Physician Name: _____

Address: _____

City, State, Zip: _____

Office phone: _____