



Carteret Community College
Massage Therapy Program Application



Semester Requested (Check One): [] Fall [] Summer [] Spring Year: _____

Please Type or Print Clearly

1. Name: _____
First Name MI Last Name

2. Mailing Address _____
City _____ State _____ County _____

3. Telephone: Cell _____ Home _____

4. Email Address: _____

5. Birthdate _____ SSN: _____ - _____ - _____

6. Sex: [] Female [] Male

7. Ethnicity: [] Hispanic Latino [] Non-Hispanic Latino [] Non-Resident Alien [] Mexican [] Puerto Rican

8. Race: [] White [] Black [] Indian [] Hispanic [] Asian [] Other

9. Highest Grade Completed: [] GED [] Adult/High School Diploma [] 1 Year Vocational Diploma
[] Associate Degree [] Bachelor's Degree [] Master's Degree +

10. Employment: [] Unemployed [] Retired [] Full Time [] Part Time (Employer): _____

11. Military Status: [] Active (Branch) _____ [] Retired [] Active Duty Dependent

Signature: _____ Date: _____

For Internal Use Only-Please Do Not Write Below This Line

- [] Medical Form [] Birth Certificate
[] Transcripts (GED, High School, and/or college) [] TABE Score _____
[] CPR/BLS Valid Through _____ [] Professional Behavior/Attend. Contract
[] Student Enrollment Agreement [] Background Check
[] Received 1 documented professional Massage from an NC Licensed Massage Therapist
[] Fees Paid



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I. Course Details:

Class size: Limited to the first 10 students that submit required documents and payment via appointment.

Instruction: You will meet on Monday – Thursday. Times will be posted online.

Before you can enroll in the program, you need to complete the following:

1. Complete the Medical Form
2. Provide Transcripts (GED, High School, and College)
3. Provide TABE Score (waived if attended college)
4. Get 1 documented professional Massage from an NC Licensed Massage Therapist
5. Complete Background Check (must be completed before the census date of class)

Massage I Registration Fee: \$180
Insurance Fee: \$22.00
Tech Fee: \$5.00
CPR Card Fee: \$5.00
Supply Fee: \$20
Total: \$232.00

Massage I Registration Fee: \$180
Insurance Fee: \$22.00
Tech Fee: \$5.00
Supply Fee: \$25
Total: \$232.00

Additionally, there are some extra fees that you should know about:

- \$335: Books for Massage I (Purchased from College Bookstore)
- \$130: Books for Massage II (Purchased from College Bookstore)
- \$50.00: Two Black Scrub tops with Monogram
- \$Varies: Background check (See packet for information)
- Credential: \$495

Please note that prices may change, so confirming the current prices before enrolling is best.



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Massage I Textbooks

- Anatomy Coloring Book ISBN: 9780133926989
- Trail Guide to the Body (Student Workbook) ISBN: 9780991466672
- Trail Guide to the Body ISBN: 9780998785066
- Massage Therapy Principles and Practices ISBN: 9780323881210
- Applied Anatomy & Physiology for Manual Therapists ISBN: 9780998266367
- Applied Anatomy and Physiology for Manual Therapists Review Guide ISBN: 9780998266374

Massage II Textbooks

- Kinesiology for Manual Therapies ISBN: 9780073402079
- Massage Therapist's Guide to Pathology ISBN: 9780998266343
- Success from the Start ISBN: 9780803625754



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Student Medical Form

Massage Therapy

Full Name (print): _____ **Date Submitted:** _____

ID# (or SS#): _____

DO NOT SEPARATE THESE FORMS

It is very important that you read and follow all directions in this packet.

Make sure all information is complete before turning in your packet.

Partial packets will not be accepted. Thank you.

PLEASE MAKE A COPY OF THESE FORMS FOR YOUR RECORDS.

Notice: Admission and/or continued enrollment of a student in a Health Sciences program is contingent upon documentation of physical and emotional health.

1. Hepatitis B Vaccine
 - a. The vaccine is recommended but not required for Therapeutic Massage students.
2. DTP or Td (Tetanus)
3. Polio
4. MMR
5. Varicella (Chicken Pox)
6. TST (Tuberculin)

GUIDELINES FOR COMPLETING IMMUNIZATION RECORD

IMPORTANT: The immunization requirements must be met in order to participate in the clinical portion of a Health Sciences program.

Acceptable Records of Your Immunizations May Be Obtained from Any of The Following: (Be certain that your name, date of birth, and ID Number appear on each sheet and that all forms remain together. The records must be in black ink and the date of vaccine administration must include the month, day, and year. **KEEP A COPY FOR YOUR RECORDS.**)

- High School Transcripts – These **may** contain some, but not all of your immunization information. Contact your high school for these records if needed for immunization purposes.
- Personal Shot Records – Must be verified by a physician’s stamp or signature, or by a clinic or health department stamp
- Local Health Department
- Military Records or WHO (World Health Organization Documents)
- Previous College or University – **Your immunization records do not transfer automatically. You must request a copy**

Note: Gather all your immunization records and discuss them with your healthcare provider. You may need to obtain additional immunizations and/or titers. Discuss requirements with your individual program faculty early to avoid delays.

GUIDELINES:	IMMUNIZATION REQUIREMENTS ACCORDING TO AGE				Note 1-4 footnote explanations
STUDENTS 17 YEARS OF AGE AND YOUNGER					
DTP or Td ¹	Polio	Measles ^{2/3}	Mumps ^{2/3}	Rubella ^{3/4}	
3	3	2	2	1	
STUDENTS BORN IN 1957 OR LATER AND 18 YEARS OF AGE OR OLDER					
DTP or Td ¹	Polio	Measles ^{2/3}	Mumps ^{2/3}	Rubella ^{3/4}	
3	0	2	2	1	
STUDENTS BORN BEFORE 1957					
DTP or Td ¹	Polio	Measles	Mumps	Rubella ⁴	
3	0	0	0	0	

¹DTP or Tdap (Diphtheria, Tetanus, Pertussis), Td (Tetanus, Diphtheria): One Tdap booster within the last ten years.

²Measles: One dose on or after 12 months of age; second dose at least 28 days later. Must repeat Rubeola (measles) vaccine if received even one day prior to 12 months of age.

³Only laboratory proof of immunity to rubella, measles or mumps disease is acceptable if the vaccine is not taken. History of rubella, measles or mumps disease, even from a physician, is not acceptable. Attach Lab report.

⁴Nonpregnant women of childbearing age who could become pregnant should be vaccinated with MMR vaccine, or have evidence of rubella immunity.



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IMMUNIZATION RECORD – (To Be Completed If Immunization Record is not submitted)
 (Please print in black ink). To be completed and signed by a physician or clinic. A complete immunization record from a physician or clinic may be attached to this form. Students may be denied clinical privileges for refusing required immunizations, which may result in dismissal from the program.

Last Name	First Name	Middle Initial	Date of Birth (mo/day/year)	ID or SS#
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REQUIRED IMMUNIZATIONS				
	mo/day/year	mo/day/year	mo/day/year	mo/day/year
DTP or Td	(#1)	(#2)	(#3)	(#4)
Td booster				
T-dap				
Polio				
MMR (on/after age 12 months)				
MR (on/after 12 months)				
Measles (on/after age 12 months)			(Disease Date NOT Accepted) -----	Titer Date, Result, Documentation
Mumps			(Disease Date NOT Accepted) -----	Titer Date, Result, Documentation
Rubella			(Disease Date NOT Accepted) -----	Titer Date, Result, Documentation
Varicella (chicken pox) series of two doses or immunity by positive blood titer	(#1)		(#2) (Disease Date NOT Accepted)	Titer Date, Result, Documentation
Tuberculin (TST) Test within 12 months or risk assessment / symptom screening (questionnaire) completed. If you have not had a TST annually, or your risk assessment / symptom screening indicates otherwise, a two-step TST is required. -----OR----- If the prior TST is positive, a chest x-ray is required (or documentation of screening <i>annually</i> on Department of Health and Human Services "Result of TB Screening").	Date read:		(1)	(2)
	mm induration:			
	Date:			
Results:				
Flu Vaccine – Clinical facilities may require students to wear a mask during clinical rotations or refuse the student a clinical experience if the student has not had the flu vaccine.	mo/day/year		Medical Waiver if Applicable: - Documentation Attached	
Hepatitis B series -----OR----- Hepatitis A/B combination series	mo/day/year	mo/day/year	mo/day/year	Titer Date, Result, Documentation
				Medical Waiver - if Applicable: - Documentation Attached

Signature or Clinic Stamp REQUIRED:

Signature of Physician/Physician Assistant/Nurse Practitioner	Date		
Print of Physician/Physician Assistant/Nurse Practitioner	Area Code/Phone Number		
Office Address	City	State	Zip Code



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PHYSICAL EXAMINATION BY MEDICAL PRACTITIONER

Please print in black ink – Complete all of the following:

Last Name _____ First Name _____ Middle Name _____ Date of Birth (mo/day/year) _____ ID or SS# _____
 Height _____ Weight _____ TPR _____ / _____ / _____ BP _____ / _____

VISION:		HEARING:	
Corrected	Right 20/ _____ Left 20/ _____	(gross)	Right _____ Left _____
Uncorrected	Right 20/ _____ Left 20/ _____	15 ft.	Right _____ Left _____
Color Vision	_____		

A. Is there loss or seriously impaired function of any single or paired organs? Yes _____ No _____
 Explain: _____

B. Is student under treatment for any medical or emotional condition? Yes _____ No _____
 Explain treatment/medication: _____

C. Recommendation for physical activity (during patient care activities) Unlimited _____ Limited _____
 Describe limitation: _____

Based on my assessment of this student's physical and emotional health on _____, he/she
 (date)
appears to be able to participate in the activities of a health profession in a clinical setting and provide safe care to the public. YES _____ NO _____
If no, please explain

 Signature of Primary Care Physician / Physician Assistant / Nurse Practitioner

 Date

 Print Name of Physician/Physician Assistant/Nurse Practitioner

 Area Code/Phone Number

 Office Address

 City

 State

 Zip Code



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TO BE COMPLETED BY STUDENT (Please print in black ink)

 Last Name (print) First Name Middle/Maiden Name SS#* email address

 Permanent Mailing Address City State Zip Area Code/Phone Number

 Date of Birth (mo/day/yr) _____ Gender ____ M ____ F Marital Status ____ S ____ M ____ Other

Insurance Information:

Hospital/Health Insurance (Name and Address of Company) Area Code/Telephone Number

Emergency Contact Information:

Name of Person to Contact in Case of Emergency Relationship



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Mind Your Business, Inc.
500 Beverly Hanks Ctr, Hendersonville, NC 28792
Tel: (828) 698-9900 Fax: (828) 698-9918
Email: mail@mybinc.com

CARTERET COMMUNITY COLLEGE – Massage Therapy

Student Online Criminal Background Check Request Procedure

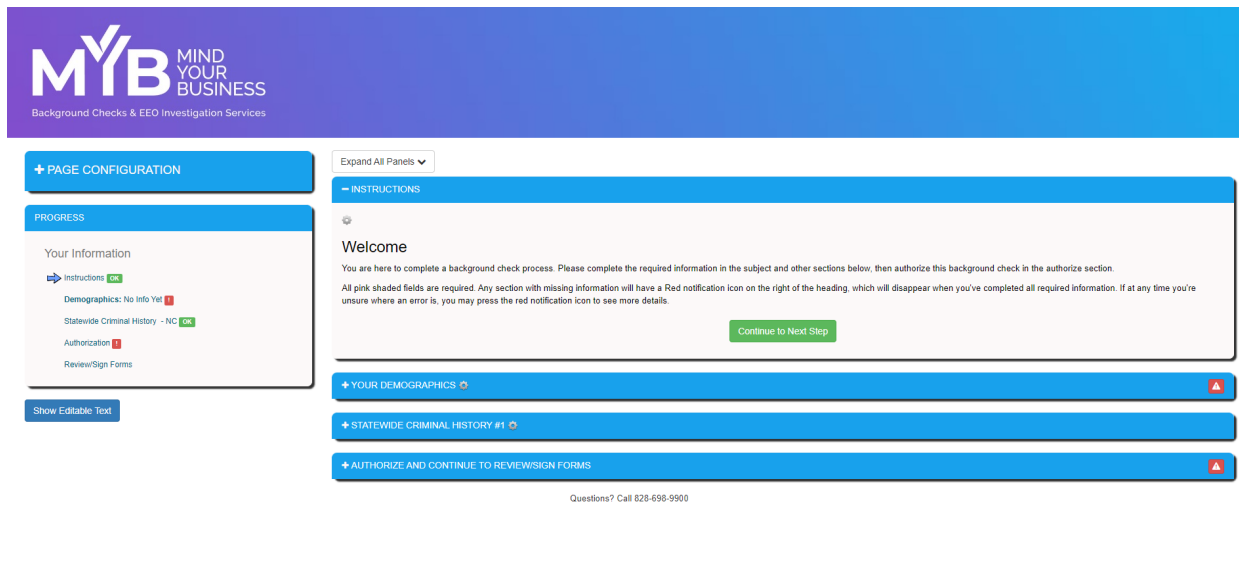
The cost for your Criminal Background Check is a flat fee of \$40

Procedure Go to

https://mindyourbusiness.bgsecured.com/c/p/unsolicited_portal?guid=VW7zdAwB9BSjHC9CX6t94vPHB4oofsPO
or <https://bit.ly/massagebgck>

a.

You will see the below home screen.

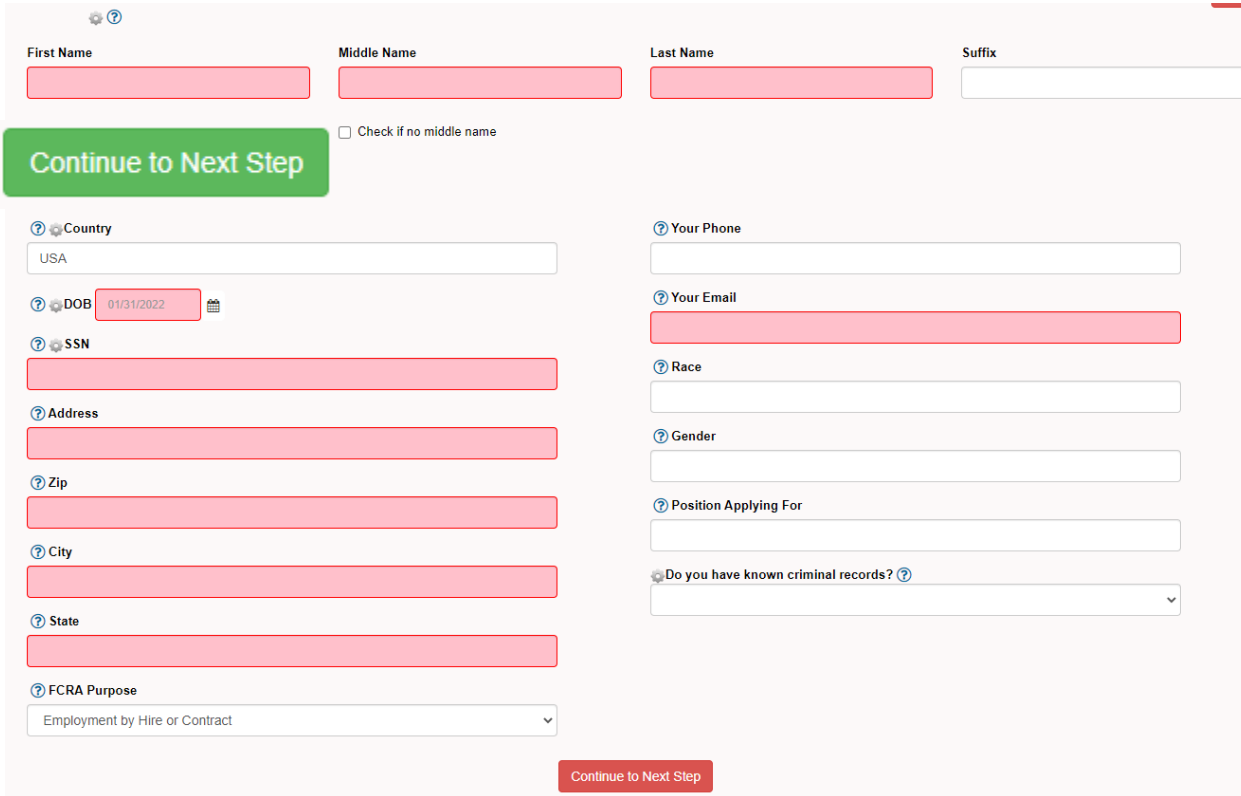


The screenshot shows the MYB Mind Your Business home screen. The header includes the MYB logo and the text "Background Checks & EEO Investigation Services". Below the header, there is a "PAGE CONFIGURATION" button and an "Expand All Panels" dropdown menu. The main content area is titled "INSTRUCTIONS" and contains a "Welcome" message. The message states: "You are here to complete a background check process. Please complete the required information in the subject and other sections below, then authorize this background check in the authorize section. All pink shaded fields are required. Any section with missing information will have a Red notification icon on the right of the heading, which will disappear when you've completed all required information. If at any time you're unsure where an error is, you may press the red notification icon to see more details." Below the message is a green "Continue to Next Step" button. On the left side, there is a "PROGRESS" section titled "Your Information" with a list of items: "Instructions" (checked), "Demographics: No Info Yet" (red notification icon), "Statewide Criminal History - NC" (checked), "Authorization" (red notification icon), and "Review/Sign Forms" (red notification icon). Below the progress section is a "Show Editable Text" button. At the bottom of the main content area, there are three expandable sections: "YOUR DEMOGRAPHICS", "STATEWIDE CRIMINAL HISTORY #1", and "AUTHORIZE AND CONTINUE TO REVIEW/SIGN FORMS", each with a red notification icon. At the very bottom, there is a small text link: "Questions? Call 828-698-9900".

b. Click

Continue to Next Step

c. Fill in all required fields in red.



The screenshot shows a registration form with the following fields:

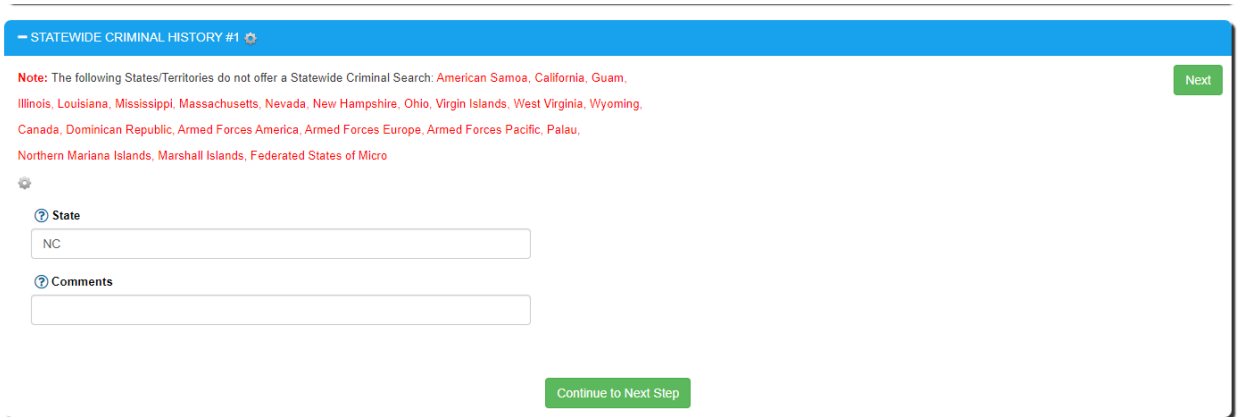
- First Name, Middle Name, Last Name, Suffix (all redacted)
- Check if no middle name
- Country: USA
- DOB: 01/31/2022
- SSN (redacted)
- Address (redacted)
- Zip (redacted)
- City (redacted)
- State (redacted)
- FCRA Purpose: Employment by Hire or Contract
- Your Phone (redacted)
- Your Email (redacted)
- Race (redacted)
- Gender (redacted)
- Position Applying For (redacted)
- Do you have known criminal records? (dropdown menu)

Buttons: "Continue to Next Step" (green), "Continue to Next Step" (red)

d. The system

automatically populates North Carolina as the state. Click

e. Click the box that says "I consent to digital signatures and authorization, and I



The screenshot shows the "STATEWIDE CRIMINAL HISTORY #1" section with the following content:

- Note: The following States/Territories do not offer a Statewide Criminal Search: American Samoa, California, Guam, Illinois, Louisiana, Mississippi, Massachusetts, Nevada, New Hampshire, Ohio, Virgin Islands, West Virginia, Wyoming, Canada, Dominican Republic, Armed Forces America, Armed Forces Europe, Armed Forces Pacific, Palau, Northern Mariana Islands, Marshall Islands, Federated States of Micro
- State: NC
- Comments (empty)
- Buttons: "Next" (green), "Continue to Next Step" (green)

authorize this background check to be performed on me." Then click

Continue To Next Step - Review/Sign Forms

AUTHORIZE AND CONTINUE TO REVIEW/SIGN FORMS

I consent to digital signatures and authorization, and I authorize this background check to be performed on me. [Learn more about the Fair Credit Reporting Act \(FCRA\)](#)

Continue To Next Step - Review/Sign Forms

f. You will see the below message.



Click

Please Supply Required Documentation

In order to complete your application, we need some additional documentation from you. Please click Continue to Next Step below to supply this documentation to us.

Continue to Next Step

g. There are two documents to sign and one document to review. Click each document and complete the next step.

Please Fill-Out/Sign Documents


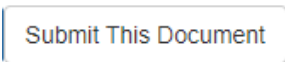
Instructions:
Click each link below to display and review the document. If a document has a red ball next to it (●), then it requires you to fill out data and possibly a signature. If a document has a yellow ball next to it (●), then it only requires review.

Once each document has been reviewed and/or filled out in the list below, you may continue to the next step.

Documents:

- [Disclosure of Intent to Obtain Consumer Report or Investigative Consumer Report](#)
- [Authorization to Obtain Consumer Report or Investigative Consumer Report](#)
- [FCRA and A Summary of Your Rights](#)

h. Review the document. Click the yellow box and digitally sign.

Click  . Then Click  . Repeat for all documents.

Download document

05/03/2022
Date Received
JOHN DOE
Printed Name
Signature

REV: 4/19


Next Submit This Document

- i. If you would like a copy of your signed forms, you can download them by clicking "Click here to download/view/print the signed release form(s)." Click

Continue to Next Step

Please Fill-Out/Sign Documents

Thank You! Your signature has been saved.

 Click here to download / view / print the signed release form(s).
You may also review the documents when you reach the 'Review and Submit' step.

Return To Forms Continue to Next Step

- j. Lastly, you will find the payment page. Please fill in all required fields in

red. Then click

Submit payment

Pay with Credit Card

Name on Card:

First

Last

Card number

Expiration Month (1-12) Year

Company Name On Card (if any)

Card CVV Code

Card Billing Address:

Address

City State Zip

Submit payment

- k. Once submitted, your background check will begin to process. You will receive an email with your purchase receipt. Additionally, within 24 hours, you will receive an email from MYB with direction regarding your drug testing. The location closest to your address will be provided as well as the time frame in which the test needs to be completed by.

If you do not have access to a computer, experience technical difficulties, or have a question, please contact MYB at mail@mybinc.com or by calling 828-698-9900.