



PROTECT PEOPLE & PROMOTE BUSINESS

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MESSAGE THERAPIST EXPERIENTIAL ACTIVITY FORM

Authority: 1978 PA 368, as amended
An Evaluative Component for Credits earned under Activity Code 6.

Form with fields: Licensee's First Name, Middle Name, Last Name, Email Address, Daytime Phone, 10-Digit MI Permanent ID/License Number, Street Address, City, State, Zip Code

Pursuant to Rule 338.741(2), Activity Code 6 of the Administrative Rules, one hour of continuing education shall be granted for each 50 to 60 minutes spent identifying, researching, and resolving the issue or event as it relates to the clinical or professional practice. A maximum of 10 hours of continuing education may be earned for this activity in each renewal period. If audited, you must successfully complete this Experiential Activity Form.

PLEASE PROVIDE A COPY OF THE INFORMATION BELOW REGARDING EACH EVENT OR ISSUE

EVENT/ISSUE #1

Form with fields: Description of event/issue, Date of event/issue, Location of event/issue, Summary of event/issue, Describe what steps you took in identifying, researching and addressing the event/issue.

Form with fields: MT's Full Name, 10-Digit MI Permanent ID/License Number

NOTE: YOU MAY MAKE ADDITIONAL COPIES OF THIS PAGE AS NEEDED.

EVENT/ISSUE # _____ of _____

Description of event/issue:	Date of event/issue:
Location of event/issue:	
Please provide a brief summary of the event/issue and how it relates to the practice of massage therapy (copies of the research is required such as research paper, PowerPoint presentation, etc.):	
Describe what steps you took in identifying, researching and addressing the event/issue. (If necessary, attach additional pages)	

EVENT/ISSUE # _____ of _____

Description of event/issue:	Date of event/issue:
Location of event/issue:	
Please provide a brief summary of the event/issue and how it relates to the practice of massage therapy (copies of the research is required such as research paper, PowerPoint presentation, etc.):	
Describe what steps you took in identifying, researching and addressing the event/issue. (If necessary, attach additional pages)	

CERTIFICATION

I certify that the information provided in this document is a true and complete record of my credits earned under R 338.741(2), Activity Code 6.

Signature of Massage Therapist

Print or Type Name

Date

NOTE: Unsigned forms will be considered incomplete and not accepted