
APPLICATION CHECKLIST

The Admissions Committee reviews completed applications submitted to NYIM.

The committee reserves the right to reject any applicant or require additional schooling/testing for any applicant it deems appropriate.

A complete application includes all the following:

- 1) A completed Admissions Application both front & back (enclosed). Also a non-refundable check or money order in the amount of \$25.00 for the application fee.
- 2) Official Regents or General high school transcripts (complete) or copy of your GED, mailed directly to NYIM from your high school. High school transcripts/GED must be on file with NYIM, regardless of higher education.
- 3) An official transcript from all college/massage schools you attended. (If requesting transfer credit)
- 4) A Medical Release Form signed by **you and your physician** (enclosed).
- 5) Two letters of recommendation, personal or professional (no relatives please). Letters should include how long they have known you and why they think you would be a successful massage therapist.
- 6) Complete a personal interview with an Admissions representative.
- 7) A completed Background Check Release Form (enclosed). This form releases information on any prior criminal convictions. NYIM will obtain the police report once the release form is submitted. If the applicant has not lived in the current county of residence for at least thirty (30) days, an additional background release form and fee must be submitted for a background check in the previous county of residence. A non-refundable processing check of \$15.00 + tax (Erie County) / \$20.00 + tax (Non-Erie County) is required.
- 8) Two forms of ID:
 - a) Driver's license or government-issued photo ID
 - b) Social Security card
- 9) Must meet with Financial Aid.
- 10) Complete a second interview, including admissions testing. (NYIM staff will call you to arrange a second interview).

NEW YORK INSTITUTE OF MASSAGE, INC.

Application for Admission

You are encouraged to submit your application as soon as possible. Classes are limited and enrollment is closed when the class is full.

**Return this application and all final official high school, college, and vocational transcripts to:
Admissions Office / NY Institute of Massage / PO Box 645 / Buffalo, NY 14231**

Enclose a \$25 check or money order payable to: NYIM

Applications will be kept for one year (valid)

All information is confidential and is used only to determine the degree to which you may benefit from training.

Please Print

Legal Name Last		First	MI	Social Security Number	
Permanent Home Address - Number		Street		Apt.	
City		County		State	Zip
Phone ()		Who referred you?			
US Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No		Country of Citizenship, if not US:			
If not a citizen, are you a permanent resident of the US?		<input type="checkbox"/> Yes		<input type="checkbox"/> No	
If your academic records might appear under a different name, please indicate		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Last		First	MI	Age: _____ Date of Birth : _____ Height/Weight: _____	
Have you previously attended the NY Institute of Massage? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, when?		For which term do you plan to enroll? <input type="checkbox"/> January <input type="checkbox"/> April <input type="checkbox"/> July <input type="checkbox"/> October 20_____			
Are you interested in classes: <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening		How do you plan on paying your tuition? <input type="checkbox"/> Personal Loan/ Funds <input type="checkbox"/> Credit Card <input type="checkbox"/> NYIM Financing <input type="checkbox"/> 3 rd Party <input type="checkbox"/> Other _____			
Will you enter as (please check all that apply): <input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Transfer <input type="checkbox"/> Other		Will you apply for Financial Aid? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Have you been in for a tour and interview? <input type="checkbox"/> Yes <input type="checkbox"/> No					
EMPLOYMENT HISTORY <i>Please attach resume or additional sheet, if necessary.</i>					
Current Employer Name		Position:			
Address		Salary:			
		Years Worked:			
		Employment dates with current company:			
Phone Number		Does your company offer a tuition assistance program? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<p>PLEASE LIST TWO (2) REFERENCES EITHER PERSONAL OR PROFESSIONAL, NO RELATIVES PLEASE (Each reference must submit a letter of reference directly to the Institute.)</p>					
Name: _____		Name: _____			
First MI Last		First MI Last			
Address: _____		Address: _____			
Occupation: _____		Occupation: _____			
Years Known: _____ Phone: _____		Years Known: _____ Phone: _____			

SCHOOL BACKGROUND

Name of high school from which you did/will graduate: _____ Date of Graduation: _____

School Address - Number Street City State Zip

School Phone: () Diploma Earned: Regents General GED

YOU MUST SUBMIT A COPY OF YOUR HIGH SCHOOL TRANSCRIPT OR G.E.D TO THE NEW YORK INSTITUTE OF MASSAGE. PLEASE HAVE OFFICIAL TRANSCRIPTS MAILED DIRECTLY TO OUR OFFICE FROM YOUR HIGH SCHOOL.

COLLEGE EXPERIENCE / MASSAGE SCHOOL EXPERIENCE

If you have attended a college, university, or massage school, list names and dates attended. (List schools whether you earned credit or not.)

Name of College/ Message School 2yr/4yr Public/Private City & State From M/Y To M/Y Credit Hours Graduate: Y/N Degree(s)

Will you be applying for transfer credit? Yes No NOTE: Before any student may be admitted as a transfer student, official transcripts and catalogs of previous college or vocational work must be on file in the Admissions Office before admissions acceptance.

Signature: _____ Date: _____

Are you a veteran? Yes No IF YES, Date of Enlistment _____ Date of Discharge _____ Branch of Service _____

Please write one (1) paragraph telling us why you are interested in the NY Institute of Massage:

Are you currently taking any medication? Yes No If yes, what type? _____

Are you under a physician's care? Yes No If yes, what for? _____

Is there anything you would like us to know about your physical or mental condition? _____

Do you have any disabilities that you would like to voluntarily disclose? If so, what reasonable accommodations would you need to ensure a high quality education? _____

Please Note: New York Institute of Massage requires a medical release form stating that you are eligible for giving and receiving massage.

Have you ever been convicted of a crime (felony or misdemeanor) or pleaded guilty to a crime in any state or country? Yes No If yes, a copy of the police report must be submitted to the Admissions office, and please explain details below.

In order to comply with Federal Reports we need to know the following Ethnic Background information: Hispanic/Latino Asian Native Hawaiian or Other Pacific Islander American Indian or Alaskan Native White Black or African American Nonresident Alien Race and Ethnicity Unknown Two or more races

Person to notify in case of emergency: _____ Telephone: (_____) _____

Relationship: _____

Nearest adult relative NOT living at your address (include complete address and phone number)

Name: _____ Telephone: (_____) _____

Address (street, city, state, ZIP): _____

Please Read Carefully and Sign

I certify that the information on this form is both complete and accurate. I understand that falsifying any part of this application may result in my being refused admission or being required to withdraw from the Institute.

Applicant's Signature _____ Date: _____

MEDICAL RELEASE FORM

**Please submit this form to your physician and have him/her complete and return to:
PO Box 645, Buffalo, NY 14231.**

Note: Your application is not complete until we have received this form.

_____	() -
Student Name	Phone Number
_____	_____
Address	Date of Birth
_____	_____
City State Zip	Social Security #

I _____ authorize my physician to release needed medical information to the New York Institute of Massage.

SIGNATURE

Dear Physician:

The person listed above is applying to become a student at the New York Institute of Massage. Massage training requires students to be in contact, through touch, with clients and fellow students. Over the 12 or 24-month training period, the student will give and receive massage almost daily. Please verify that this student is free of any infectious diseases, current on MMR immunizations, has no medical / psychological condition, or contraindications, which would prevent him/her from performing or receiving massage and/or bodywork and has no allergies to: latex, rubbing alcohol, lotions, oils, nuts, foods or carpeting. Please verify information on the reverse side of this form by your signature and office stamp.

_____	_____
Physician's Name (please print)	Date
_____	_____
Physician's Signature	Address
_____	_____
Phone Number	City State Zip

Physician Comments: _____

To be completed by applicant:

1. Have you been diagnosed with a medical/psychological condition? If yes, please explain: _____

2. How long have you had this condition? _____

3. Have you had similar conditions in the past? If yes, describe: _____

4. What activities aggravate your condition? _____

5. Is the condition getting progressively worse? Y N Constant? Y N Sporadic? Y N

6. Is the condition interfering with: work sleep daily routine ?

7. List surgical operations or significant injuries and dates: _____

8. Are you taking prescription medication? Please list: _____

9. Are you pregnant? YES NO MAYBE If yes, how many weeks? _____

*Students at any stage of pregnancy require written documentation from their treating physician releasing the student to participate with no limitations and/or restrictions.

PLEASE INDICATE WITH A CHECK MARK IN THE BOX TO THE RIGHT OF EACH COLUMN, THE FOLLOWING CONDITIONS YOU HAVE OR HAVE HAD:

Alcoholism	Circulatory Condition	Herpes (1 or 2)	Scarlet Fever	
Allergies, Please List: Include Foods	Diabetes	High Blood Pressure	Scoliosis	
_____	Diagnosed Learning Disability	Influenza	Stroke	
_____	Eczema	Intestinal Problems	Tuberculosis	
_____	Emboli/Thrombosis	Low Back Pain	Thyroid	
Anemia	Emphysema	Mental Illness	Varicose Veins	
Aneurysm	Epilepsy	Migraines	Visual Impairment	
Arteriosclerosis	Fibromyalgia	MS		
Arthritis	Goiter	Neuralgia		
Asthma	Gout	Osteoarthritis		
Cancer	Headaches	Osteoporosis		
Carpal Tunnel Syndrome	Heart Disease	Pleurisy		
Cervical (Neck) Pain	Hepatitis	Pneumonia		
Chronic Fatigue Syndrome	Hernia	Rheumatoid Arthritis		

