



The Society for Oncology Massage, Inc.

Professional/Associate Membership Application

I. Please identify yourself: (please complete all lines)

Print Full Name and Professional Designators: _____

Mailing Address: _____

City, State and Zip: _____

Permanent e-mail address: *Required* _____

II. Provide A Temporary Password

If you are applying for Professional Membership, print a temporary password for your use to access your record in the Therapist Locator Service. You may use letters and digits. Please distinguish clearly between upper and lower case letters:

Your Password: _____

III. Please complete and initial the following items:

___ I am applying for ___ professional or ___ associate membership. (Please check one.)

___ I attest that I have actively practiced massage therapy for at least one year, treating approximately ___ clients, using the following modalities (listed in order from most used to least: _____, _____, _____, _____, _____, _____).

___ I further attest that I have read and will adhere to the S4OM Standards of Practice for Oncology Massage.

___ I attest that I will accurately maintain my record in the Therapist Locator Service, including total cumulative oncology massage hours, updating it not less than annually (Professional Members only).

Signature: _____ Date: _____

I attest that I have carefully and accurately completed this application.

IV. Please attach copies of the following documentation,

Check off each item and staple behind this application in the order listed.

- ___ 1. A copy of your current state and/or local massage therapist licenses, as required by law, or a signed statement that none are required.
- ___ 2. A copy of your current certificate of professional liability insurance listing massage as a covered activity. (An organization certificate of membership is not sufficient.)

3. General Massage Training Options *Select only 1 of 3.*

___ A copy of your graduation certificate from a massage therapy training program of 500 hours or more. (If the certificate does not state the number of hours, please attach a letter from the school that so states.)

-or-

___ A copy of your graduation certificate from a massage therapy training program of 300 hours or more plus copies of certificates of completion from NCBTMB approved continuing education courses, to total 500 hours in all. (If the certificate from the massage therapy training program does not show the number of hours, please attach a letter from the school that so states.)

-or-

___ Submit a letter of no more than 750 words explaining how you have acquired equivalent general massage training through your specific education, training, work history and life experience. Such requests are considered on an individual basis. You may be asked for a telephone interview. *Do not send any additional materials until you are asked to do so.* Approval will be granted at the sole discretion of the Membership Committee.

4. Oncology Massage Training Options *Select only 1 of 2.*

___ A copy of your certificate of completion of an S4OM recognized oncology massage training program of 24 hours or more.

-or-

___ Complete the oncology massage training checklist to explain how you have acquired equivalent oncology massage training through your specific education, training, work history and life experience. Such requests are considered on an individual basis. You may be asked for a telephone interview. *Do not send any additional materials until you are asked to do so.* Approval will be granted at the sole discretion of the Membership Committee.

And, if you are applying for Professional Membership at this time:

5. Hands-on Oncology Massage Session Options *Select only 1 of 2.*

___ This requirement demonstrates your mastery of the clinical thinking skills learned in (4) above. These sessions may be performed in any massage setting such as a hospital, private practice, spa, or allied health practice.

-or-

_____ Provide evidence of completion of an additional, advanced, S4OM recognized training session of 35 hours or more that incorporates detailed, supervised hands-on work.

V. Please make a check payable to The Society for Oncology Massage, Inc.

Every application must be accompanied by a check.

Membership dues are \$60.00 per year. The membership year is 4/1 - 3/31.
All memberships are renewed in March.

Postmark Month	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
Initial Dues Payment	\$75	\$70	\$65	\$60	\$55	\$50	\$45	\$40	\$35	\$30	\$25	\$20
Membership for	15 mos.	14 mos.	13 mos.	12 mos.	11 mos.	10 mos.	9 mos.	8 mos.	7 mos.	6 mos.	5 mos.	4 mos.

VI. Review, Copy, Staple, Clip and File

To avoid a delay or the return of your materials, please review your application. *Be sure you have included everything specifically requested. Be sure you have removed anything not specifically requested.*

Make two complete copies of your application package. Staple each copy in the order specified and paper clip the check to one copy.

Retain the first copy for your records in case your application goes astray in the mail.

VII. Send the original, the second copy and your check in one envelope, by first class or priority mail only. Do not send certified or by any method requiring a signature. Deliveries requiring a signature can not be accepted. Mail to:

Society for Oncology Massage
Membership Committee
c/o Mia Harper
508 Bay Hills Dr.
Arnold, MD 21012

Thank you for your application. We will make every effort to respond by e-mail within 8 weeks. We look forward to your participation in S4OM.



Amended January 22, 2010



Session Notes - Summary Format

Therapist Name: _____

This sheet will demonstrate your clinical thinking skills. Answer thoughtfully and completely. Please *type or print carefully* - writing cannot be processed. A Word version is available at: www.s4om.org/div1/documents/session_notes_summary1.doc . (Effective examples are at www.s4om.org/div1/documents/typical_session_notes.pdf)

Client #1 of 4

Client's Age: _____

Client's Gender: _____

Date of Session: _____

Length of Session: _____ (1 hour minimum)

Cancer diagnosis: _____

Treatment history: _____

Current cancer physical conditions: _____

Other current medical conditions: _____

How and why did you modify standard massage for this client? _____

Therapist Signature: _____



Session Notes - Summary Format

Therapist Name: _____

This sheet will demonstrate your clinical thinking skills. Answer thoughtfully and completely. Please *type or print carefully* - writing cannot be processed. A Word version is available at: www.s4om.org/div1/documents/session_notes_summary1.doc . (Effective examples are at www.s4om.org/div1/documents/typical_session_notes.pdf)

Client #2 of 4

Client's Age: _____

Client's Gender: _____

Date of Session: _____

Length of Session: _____ (1 hour minimum)

Cancer diagnosis: _____

Treatment history: _____

Current cancer physical conditions: _____

Other current medical conditions: _____

How and why did you modify standard massage for this client? _____

Therapist Signature: _____



Session Notes - Summary Format

Therapist Name: _____

This sheet will demonstrate your clinical thinking skills. Answer thoughtfully and completely. Please *type or print carefully* - writing cannot be processed. A Word version is available at: www.s4om.org/div1/documents/session_notes_summary1.doc . (Effective examples are at www.s4om.org/div1/documents/typical_session_notes.pdf)

Client #3 of 4 Client's Age: _____ Client's Gender: _____

Date of Session: _____ Length of Session: _____ (1 hour minimum)

Cancer diagnosis: _____

Treatment history: _____

Current cancer physical conditions: _____

Other current medical conditions: _____

How and why did you modify standard massage for this client? _____

Therapist Signature: _____



Session Notes - Summary Format

Therapist Name: _____

This sheet will demonstrate your clinical thinking skills. Answer thoughtfully and completely. Please *type or print carefully* - writing cannot be processed. A Word version is available at: www.s4om.org/div1/documents/session_notes_summary1.doc . (Effective examples are at www.s4om.org/div1/documents/typical_session_notes.pdf)

Client #4 of 4

Client's Age: _____

Client's Gender: _____

Date of Session: _____

Length of Session: _____ (1 hour minimum)

Cancer diagnosis: _____

Treatment history: _____

Current cancer physical conditions: _____

Other current medical conditions: _____

How and why did you modify standard massage for this client? _____

Therapist Signature: _____