



**THE INSTITUTE OF THERAPEUTIC MASSAGE, INC.**

PH #: 866-897-0949

FAX #: 419-523-9152

*A PROFESSIONAL EDUCATION FOR A PROFESSIONAL CAREER*

**HEALTH CERTIFICATION FORM**

This form does not require a Physical Examination, unless required by the Physician.  
A review of the applicant's medical records is adequate.

Applicant Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

To be completed by a Physician only.

The above-named individual has applied to the Institute of Therapeutic Massage for consideration in enrollment. Students of Medical Massage come in touch contact with other students and clinical patients during their educational process. Students must be free of contagious diseases and have the physical capabilities to apply therapeutic techniques.

	Yes	No
Has the applicant ever had a serious injury or medical/mental illness?	___	___
Is the applicant now under the care of a physician or taking any medications?	___	___
Has the applicant ever blacked out or lost consciousness during physical activity?	___	___
Should there be any limitations placed on the applicant's participation?	___	___
<u>Abnormal physical findings (including infectious or contagious diseases)?</u>	___	___

If yes, please specify/recommendations.

Tuberculosis Skin Test. Date: \_\_\_\_\_ Results: \_\_\_\_\_

I certify that I have on this date examined the records of this applicant and that, on the basis of the examination and the applicant's medical history; I have found no reason which would make it medically inadvisable for this individual to participate in a course of study, both academic and practical, for Licensed Massage Therapist.

Physician's Name: \_\_\_\_\_ Ph. #: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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