Health Endorsement

This verifies that on

_____

Examination Date (MM-DD-YYYY)

I examined

_____

Applicant's Full Name

I have determined that he or she is healthy and free of any diseases or conditions that might pose a danger to the public during the course of providing massage therapy services.

I certify that I am authorized to provide the information requested above, the information provided is accurate, and that this information is recorded in the applicant's medical file with this office.

_____

Physician's Signature

_____

Physician's Printed Name

_____

Date Signed (MM-DD-YYYY)

_____

Physician's Business Telephone Number (including Area Code)

_____

Physician's Business Address (Street and Number, City, State, and Zip Code)