ALLIED HEALTH SUPPLEMENTARY APPLICATION

Please complete this section for all Massage Therapists on Staff:

NAME OF ALLIED HEALTH PROFESSIONAL	TYPE(S) OF SERVICES THEY PERFORM (please list all)	YEARS OF EDUCATION	YEARS OF EXPERIENCE

1. Do you collect and discuss the client's health information? ☐YES ☐NO

2. Is a waiver signed, dated, and kept on record? **(**Must be kept on file for min. 7 years)** ☐YES ☐NO

3. Do you have Professional Liability Insurance through your current medical association? ☐YES ☐NO

4. Have any of the Allied Health professionals listed above had a claim made against them under CGL or Professional Liability? ☐YES ☐NO

   If so, please advise:

5. Do you keep copies of all client service records? ☐YES ☐NO

6. Are you certified in your relevant profession? ☐YES ☐NO