MASSAGE SUPPLEMENTARY APPLICATION

Please complete this section for all Massage Therapists on Staff:

NAME OF MASSAGE THERAPIST	TYPE(S) OF MASSAGE THEY PERFORM (please list all)	YEARS OF EDUCATION	YEARS OF EXPERIENCE	ARE YOU AN RMT?	
				YES	NO
				☐	☐
				☐	☐
				☐	☐
				☐	☐

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 offer massages to infants? ☐YES ☐NO
4. Have any of the masseuses listed above had a claim made against them? ☐YES ☐NO

   If so, please advise: