PHYSICIAN PERMISSION
FOR MASSAGE TREATMENT

Physician's Name:_____

Physician's
Address:_____

Physician's Telephone(_____)_____

I have been treating this patient: _____

DOB:_____Since_____

For the following condition(s):

_____

_____

_____

_____

There is no reason to believe that massage or bodywork treatments will harm this patient's progress. However, please note that the following considerations/medication warrant special concern:

_____

_____

_____

_____

_____

Should you notice anything unusual or suspicious in the treatment or progress of this patient, please notify my office immediately.

Physician's Signature_____

Date_____