

MASSAGE ARTS CENTER OF PHILADELPHIA
HEALTH CERTIFICATE

Please complete and return to:
Massage Arts Center of Philadelphia
519 S 4th St
Philadelphia, PA 19147
Fax (267) 321-0266

Student Name _____

Social Security # _____

Physician's Name _____

License# _____

Office Address _____

Office Phone# _____

A licensed physician must complete the remainder of this form.

1. I hereby certify that a PPD (TB Screening) was administered to the above named individual at this office on _____. Results: Negative _____ Positive _____ if positive indicate actions taken.

2. I hereby certify that the above named individual is able to participate in massage classes and able to give and receive massage during these classes.

Physician's Signature _____

Date _____