MEDICAL CLEARANCE FORM

I give permission for the physician to release this medical information to First College for the purpose of admission requirements. All information will remain confidential.

Individual's Name (print): _____ DOB: _____

Individual's Signature: _____

This medical clearance is to certify the following individual is physically and psychologically able to fully participate and attend the two-year Registered Massage Therapy (RMT) program including all clinical aspects.

Physician Information:

Name: _____ Phone Number: _____

Address: _____

Physician Use Only:

Please check one of the following statements

	I approve the individual's participation in the RMT program with no restrictions
	I approve the individual's participation in the RMT program with the following restrictions:
	I recommend the individual not participate in the RMT (if checked, the individual will not be accepted into the RMT program

Physician's Notes: _____

_____

Physician's Name (print): _____

Physician's Signature: _____ Date: _____