

**BLANCHARD VALLEY ACADEMY OF MASSAGE THERAPY
1710 CRYSTAL AVENUE
FINDLAY, OHIO 45840**

**Medical Examination Request
Completed Form Must Accompany Application**

NAME _____ AGE _____ SEX _____

Dear Doctor:

Please examine the above named prospective student for any sign of communicable diseases or other reasons that would be contra-indicated in the practice of massage.

REMARKS: _____

In my opinion the above DOES, DOES NOT appear as having a communicable disease or other condition that would be contra-indicated in the practice of massage.

Date: _____ Signed _____

Address _____

Phone _____