

Physician's Approval Letter

Student Name _____

Date of Birth _____

The student named above will be applying for admission to the 18 month massage therapy training program at the Atlantic College of Therapeutic Massage.

This health condition statement is to be completed and signed by the student's physician.

As the student's physician, you are hereby confirming that you have examined the student and that you are not aware of any:

- a) communicable disease currently affecting the student; and
- b) physical or mental condition which would affect the student's ability to attend and participate in the massage therapy program.

If the student has disclosed to you any diagnosed learning disability for which the student has received resources and/or support during previous education, please describe the nature of the learning disability below, so that we may make accommodation for the student.

Comments (if any) _____

Dated this _____ day of _____ 20 _____

Please sign above and print below.