Physician's Permission

Physician's Name ____ Date ____/____/_______

Physician's Address ___________________________ City ______________________ State/Zip ______________

Physician's Phone (   ) ____-_______ Email: ____

I have been treating ____ since ____________________
(*Patient's Name*) (*Date*)

For the following conditions:
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____
____

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

Physician's Signature ____