

Physician's Certification of Fitness to Attend Clinical Massage School

This form must be signed by a licensed physician, nurse practitioner, or physician's assistant attesting to the student's physical and mental well-being.

In order to participate in Clinical Massage Program at Asheville-Buncombe Technical Community College, a student must be able to demonstrate, with or without reasonable accommodations, all functional (e.g., physical, sensory, cognitive, and behavioral) abilities required for satisfactory completion of all aspects of the program curriculum and clinical requirements.

This is to certify that _____ (Student Name) had a physical exam _____ (Date of Exam) and certify that in my professional judgment, this student is capable of performing all requirements of the rigorous and strenuous Clinical Massage Program at Asheville-Buncombe Technical Community College.

_____ No concerns

_____ Concerns or Restrictions

Signed: _____ (Physician's Signature)

MD's printed name: _____

Office address: _____

Phone number: _____

Fax number: _____

Date: _____

Signature is Required.

***Please return this form to:** Attn: Teresa Robinson MSN RN Health Occupations Coordinator
E-mail: teresamrobinson@abtech.edu
Or, Mail to: AB Tech. Com. College
340 Victoria Road Asheville, NC 28801
(Or, Fax to 828-281-9720 with Confidential Cover Sheet)