



MidMichigan THERAPEUTIC MASSAGE CARE

Improving the quality of living. One person at a time.™

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Physician's Permission Form

Patient: _____

Physician's Name: _____

Physician's Address: _____

Physician's Telephone: _____

I have been treating this patient since _____ for the following condition(s):

There is no reason to believe that massage therapy treatments will harm this patient's progress. However, you should take the following considerations/medication into your massage treatment plan:

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

Physician's Signature: _____ Date: _____