MASSAGE THERAPY LICENSING PROGRAM
Employment Affidavit

Instructions: This form is to document employment experience. Please use a separate employment affidavit for each organization or institution where the experience was gained. Refer to the Instruction/Declaration Form, method 3, and to 25 TAC§141.10(a)(3) & §141.11 of the rules. Submit experience sufficient to document the five-year requirement. Photocopy this form if additional copies are needed.

Section I. (Completed by applicant)

Name of Applicant _____

Address of Applicant

P O Box or Street No. City State Zip

Section II. (Completed by employer)
The employer certifying to his/her knowledge the experience of the applicant listed above in Section I shall complete the information below.

I, _____, certify that I have employed _____

from _____to _____ and that said person was employed as follows:
MM/DD/YY MM/DD/YY

1. Address of Employment _____

2. Briefly describe techniques practiced _____

3. Job Title _____

4. Check type of establishment or office in which work was performed:

[ ] Massage Establishment [ ] Health Spa [ ] Doctor's Office [ ] Other _____

5. Total number of hours per month applicant worked in the above duties _____

6. Other pertinent information: _____

On this _____ day of _____, _____ in _____, _____.

Section III. (Completed by notary and employer)

I certify under penalty of perjury that the information submitted is true and correct.

STATE OF ( )
COUNTY OF ( )

_____
Signature of Employer

Sworn to and subscribed before me on this
_____ day of _____, _____.

_____
Address of Employer

My commission expires: _____

_____
City, State, Zip

Notary's Signature SEAL

MASSAGE THERAPY LICENSING PROGRAM
Client Affidavit Form

Instructions: This form is to document client references. The following information must be certified by two or more clients. Submit client affidavits sufficient to document five years of experience. Photocopy this form for each client. Refer to the Instruction/Declaration Form, Method 3 and to §141.10(a)(3) and §141.11 of the rules. This information shall be used for no other purpose than to verify the five-year experience requirement.

Section I. (Completed by applicant)

Name of Applicant _____

Address of Applicant

P O Box or Street No. City State Zip

Section II. (Completed by client)

Attach copies of receipt(s) for massage therapy rendered.
The client certifying to his/her knowledge the experience of the applicant listed above in Section I shall complete the information below.

I, _____, certify that I have employed _____

from _____to _____ and that said person was employed as follows:
MM/DD/YY MM/DD/YY

1. Address of business _____
2. Briefly describe techniques practiced _____
3. Number of hours per month _____
4. Check type of establishment or office in which work was performed:

[ ] Massage Establishment [ ] Health Spa [ ] Doctor's Office [ ] Other _____

5. Other pertinent information: _____

Section III. (Completed by notary and client)
On this _____ day of _____, _____ in _____, _____.

I certify under penalty of perjury that the information submitted is true and correct.

STATE OF ( )
COUNTY OF ( )

_____
Signature of Employer

Sworn to and subscribed before me on this
_____ day of _____, _____.

_____
Address of Employer

My commission expires: _____

_____
City, State, Zip

Notary's Signature SEAL

MASSAGE THERAPY LICENSING PRORAM
Affidavit of Referral(s)

Instructions: This form is to document massage therapy experience through referrals from other licensed health care professionals. Photocopy if additional copies are needed.

Section I. (Completed by applicant)

Name of Applicant _____

Address of Applicant

P O Box or Street No. City State Zip

Section II. (Completed by other licensed health care professional)

The person certifying to his/her knowledge the experience of the individual above shall complete the information below.

I, _____, as a licensed _____, do hereby
Occupation

certify that I have referred _____ patients or clients to _____
No. Applicant's Name

period of time, from _____to _____ and that I know of my own
MM/DD/YY MM/DD/YY

knowledge that said person was engaged in the professional practice of massage therapy as follows:

1. Address of business _____

2. Briefly describe techniques practiced _____

3. Check type of establishment or office in which work was performed:

[ ] Massage Establishment [ ] Health Spa [ ] Doctor's Office [ ] Other _____

4. Hours of therapy per month _____

5. Other pertinent information: _____

Section III. (Completed by notary and other licensed health care professional)
On this _____ day of _____, _____ in _____, _____.

I certify under penalty of perjury that the information submitted is true and correct.

STATE OF ( )
COUNTY OF ( )

_____
Signature of Employer

Sworn to and subscribed before me on this
_____ day of _____, _____.

_____
Address of Employer

My commission expires: _____

_____
City, State, Zip

Notary's Signature SEAL

9/05