State Medical Board of Ohio

30 E. Broad St., 3rd Floor
Columbus, Ohio 43215
(614) 466-3934
www.med.ohio.gov

MASSAGE THERAPIST
Certificate of Education

The State Medical Board of Ohio requires that this form be completed by the program where the applicant received his/her massage therapy training. Please complete this form and e-mail it to the State Medical Board of Ohio to license@med.ohio.gov.

THIS SECTION TO BE COMPLETED BY APPLICANT

Full Name: _____ DOB: _____

I hereby authorize the below-named program to furnish the information below to the State Medical Board of Ohio.

_____
Signature of Applicant

Date: _____

THIS SECTION TO BE COMPLETED BY MASSAGE THERAPY PROGRAM

Name of School/Program: _____

Address: _____

Dates of Attendance: From: _____ To: _____

Period of course instruction (months): _____ Clock Hours: _____

I certify that the applicant was awarded a degree/diploma on date: _____

I further certify that the above-named applicant has completed a massage therapy program meeting the curriculum requirements of section 4731-1-16 of the Ohio Administrative Code and as verified in the applicant's official academic transcripts.

_____
Signature of Registrar/Program Director (original signature only, name stamps are not accepted.)

Name (Printed): _____ Date: _____