

COUNTY OF SAN DIEGO

MASSAGE TECHNICIAN PHYSICAL EXAMINATION FORM

Submit completed form with Massage Technician/Trainee application to SD Sheriff's License Division.

TO BE COMPLETED BY APPLICANT: TYPE OR PRINT ONLY

Name: _____ Telephone: _____
(Last) (First) (Middle)

Date of Birth: _____ Sex: _____ Height: _____ Weight: _____ Hair: _____ Eyes: _____

Soc. Sec. No: _____ - _____ - _____ Driver's License No: _____

Residence: _____
(Number) (Street) (City) (Zip)

Business Address:
(If applicable) _____
(Number) (Street) (City) (Zip)

Date: _____
Applicant's signature

TO BE COMPLETED BY EXAMINING PHYSICIAN

I. Eyes: _____ Ears: _____ Nose: _____ Mouth: _____
Throat: _____ Tonsils: _____ Skin: _____

II. TB test results: _____

III. Evidence of communicable disease: Yes _____ No _____

IV. Is there any medical reason not to approve a Massage Technician's Permit for this person? Yes _____ No _____

Date: _____ M.D
Signature of examining physician

Address: _____

Telephone: (_____) _____

COMMENTS: _____

