



Maryland State Board of Massage Therapy Examiners

4201 Patterson Avenue, Suite 301, Baltimore, MD 21215

Main Line (410)764-4738; Email: mdh.bcmt@maryland.gov

www.health.maryland.gov/massage

SPECIAL ACCOMMODATIONS REQUEST

Name: _____

Address: _____

Street

City

State

Zip

Phone: _____ Email: _____ Date of Birth: _____

Please explain the nature of your disability. _____

Please list the medical/health professionals who have diagnosed and/or treated you for your disability.

Please describe how your disability affects major life activities. _____

What accommodations have you received for this disability in the past? _____

What accommodations are you requesting for this examination? _____

I attest that the information provided above is true to the best of my knowledge, information, and belief.

Applicant's Signature

Date



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Please include a current report (no more than 3 years) from a qualified medical professional evaluating your disability. The report must include:

- Name, title, credentials and area of specialization of the medical/health professional;
- Specific diagnosis;
- Findings in support of the diagnosis (including relevant test results);
- Recommendation for specific accommodations; and
- Rationale for requesting specific accommodations.

Documentation must be submitted on professional letterhead, typed, and contain an original signature. Inadequate or incomplete documentation will be returned.

BOARD USE ONLY

Specialist Documentation Attached to Application ____ Yes ____ No Initials ____

Disability Verified ____ Yes ____ No Initials ____

Date Special Accommodations Approved by Administrator or Designee ____ / ____ / ____

Signature of Approver _____

Approval Notice sent to applicant on ____ / ____ / ____ Initials ____

Examination Date ____ / ____ / ____