Maryland State Board of Massage Therapy Examiners

4201 Patterson Avenue, Suite 301, Baltimore, MD 21215
Main Line (410)764-4738; Email: mdh.bcmte@maryland.gov
www.health.maryland.gov/massage

SPECIAL ACCOMMODATIONS REQUEST

Name:_____

Non-Public (Home) Address: _____

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

Maryland
DEPARTMENT OF HEALTH

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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 ____ /____ /____