Maryland State Board of Massage Therapy Examiners

4201 Patterson Avenue, Suite 301, Baltimore, MD 21215
(410)764-4726
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. ____

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

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Please describe how your disability affects major life activities. ________________________________

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

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What accommodations are you requesting for this examination? ______________________________

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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 ____/____/____