Washington State Department of Health

Board of Massage - School Completion Form

This form must be presented to the test center at the time of exam. Candidates who arrive for the examination without this form or with an incomplete form will not be allowed to test.

Candidate Name: _____

Training:

Name of Program: _____

Date Program Completed: ____/____/____

Number of Hours Completed: _____

Authorized Signature: _____

School Stamp

First Aid:

Training Provided by:

_____

Date Training Completed:

____/____/____

CPR:

Training Provided by:

_____

Date Training Completed:

____/____/____

AIDS Education:

Training Provided by:

_____

Date Training Completed:

____/____/____

Previous Licensure:

List all states and /or jurisdictions in which you have been credentialed as a health care provider.

☐ I have never been credentialed as a health care provider in any other state or jurisdiction

State/Jurisdiction	License Type	License Number	Year Issued	Expiration Date