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Commonwealth of Massachusetts
Division of Professional Licensure
BOARD OF REGISTRATION OF MASSAGE THERAPY
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BUSINESS REGULATION

CHARLES BORSTEL
DIRECTOR, DIVISION OF
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VERIFICATION REQUEST

Massachusetts' Licensee: Please provide the information requested below to process your verification request. Additionally, please forward this request **along with** a check or money order for \$15.00 payable to: the Commonwealth of Massachusetts.

To Be Completed By Licensee (Please Print In Ink)

I, the undersigned Licensee, was granted a license to practice _____
(Profession)

with license number **MT**-_____ in the Commonwealth of Massachusetts. I request that the
(License #)

Board of Registration of Massage Therapy forward verification of my licensure to the recipient stated below:

Name: _____

Street: _____

City: _____ State _____

Zip Code: _____

Furthermore, I hereby **authorize** the Board of Registration of Massage Therapy to release my information, **favorable or otherwise**, directly to the above stated recipient.

Licensee's signature & Date _____

Licensee's printed or typed name _____

Licensee's Address: _____

Licensee's phone #: _____

