



New York State Society of Medical Massage Therapists - Client Referral Program

Complete this form if you are an active or senior member who would like to participate in the telephone and/or web site referral listings. Your information will be shared when potential clients call our toll free number or use the Therapist Locator search engine on our web site. ****Do not list any information you do not want given to the public. *Please print all information clearly!***

Please check one or both: Telephone Referral _____ Web Site Referral _____

Name _____		Business Name _____	
Business Address _____ (____)		City _____	State _____ Zip _____
Business Telephone _____	Email Address _____	Website Address _____	
Area(s) of Service: (List County / Borough) _____		Other Education/Degrees: _____	
NYS License # _____	Year issued _____	Other Licenses: _____	

Mark all that apply - I work in/on:

- Office _____ Out Call/On-Site _____
- Home Office _____ Other _____
- Mon-Fri _____ Hours _____
- Sat _____ Hours _____
- Sun _____ Hours _____

My workplace is:

- Wheelchair accessible with accessible bathroom
- Pet-free _____ Chemical & Perfume-free
- Near public transportation
- Train _____ Bus _____

Method of Payment: Cash / Check / Credit Card

- American Express _____ Discover _____
- MasterCard _____ Visa _____

Insurance Accepted:

- All _____ No Fault _____
- Some _____ Workmen's Compensation _____

Professional Affiliations / Certifications:

- AMTA _____ NCBTMB _____
- AOBTA _____ Other _____
- IMA _____ Other _____

I work with:

- Men _____
- Women _____
- Children _____
- Infants _____
- Clients with special needs _____
- Cancer patients _____
- Persons with HIV/AIDS _____
- Physically challenged _____
- Pregnant women _____
- Other _____

My techniques include:

- Acupressure _____
- Alexander Technique _____
- AMMA Therapy _____
- Aromatherapy _____
- Chair Massage _____
- Craniosacral Therapy _____
- Deep Tissue Massage _____
- Infant Massage _____
- Lomi Lomi _____
- Manual Lymph Drainage _____
- Myofascial Release _____
- Neuromuscular Therapy _____
- Polarity Therapy _____
- Pre-natal Massage _____
- Post-natal Massage _____
- Reflexology _____
- Reiki/Radiance _____
- Rolfing _____
- Shiatsu _____
- Sports Massage _____
- Stone Massage _____
- Swedish Massage _____
- Thai Massage _____
- Therapeutic Touch _____
- Trigger Point _____
- Zero Balancing _____
- Other _____
- Other _____
- Other _____
- Other _____

Additional information you would like your clients to know. (Maximum 20 words)

Please read and sign.

~~ I agree to conduct my practice in a manner consistent with the Code of Ethics of the New York State Society of Medical Massage Therapists and the regulations of the profession of Massage Therapy.

~~ I understand that my name can be removed from the Web site and Telephone referral list within one month's time by sending notice to the Society's mailing address.

~~ I agree to notify the Society immediately if my office address, email or phone number changes.

~~ Please note: The NYSSMMT does not investigate or in any way assess the suitability or status of any member of the public who utilizes our referral services. Each member should assess the suitability of the therapist/patient relationship for himself or herself based upon his or her usual and customary criteria.

Signature _____ Date _____

Mail to: NYSSMMT, Inc.
PO Box 442
Bellmore, NY 11710-0442

Toll Free Telephone: 1-877-NYSSMMT (1-877-697-7668)
Web Address: www.nysmassage.org

For Official Use: No. _____ Verified by _____ Entered into database on _____