



STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

MESSAGE THERAPY TEMPORARY PERMIT APPLICATION

TO BE COMPLETED BY MESSAGE THERAPIST SUPERVISOR ONLY

I _____ (full name of supervisor) am a currently licensed Connecticut massage therapist under chapter 384a, licensure number _____. I certify that, if granted a temporary permit, _____ (full name of permit applicant), will practice at _____ (where massage therapist will function) as a massage therapist only in those settings where the supervising massage therapist is physically present on the premises and is immediately available to render assistance and supervision, as needed, to the permittee.

I certify that I am employed in the setting where the temporary permittee will be employed. I understand that I must be physically present on the premises when the temporary permittee engages in massage therapy activities, and must be immediately available to the temporary permittee when needed.

I will immediately notify the Department of Public Health in writing within thirty (30) days should this supervision agreement be terminated.

SIGNATURE OF LICENSED SUPERVISOR

DATE

Day time telephone number _____ Fax Number _____

Phone: (860) 509-7603
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