THE HEALING GARDEN OF DESTINY

Physician / Maternity Provider Clearance Form

To: (Provider Name) _____

Re: (Client Name) _____ **DOB:** _____

Your patient is seeking clinical bodywork and/or labor induction massage (36+ weeks) with **Veronica Salber** in Winooski, VT. Due to the clinical nature of these services, we require provider clearance for clients with high-risk conditions.

I, Dr./Midwife _____, have evaluated the patient listed above and:

[ ] **APPROVE** clinical bodywork/massage for this patient.

[ ] **APPROVE** induction massage services (if 36+ weeks gestation).

[ ] **APPROVE WITH RESTRICTIONS:** _____

Provider Signature: _____ **Date:** _____

Provider Phone: _____