WSCC Workers' Safety & Compensation Commission | ᐃᖅᑲᓇᐃᔭᖅᑎᓄᑦ ᐊᑦᑕᓇᖅᑐᓂᒃ ᐊᒻᒪ ᓇᓪᓕᐅᒃᑯᒪᓂᒃ ᖃᐅᔨᓴᖅᑎᑦ

Massage Therapy Treatment

PLEASE COMPLETE THIS FORM

Claim Number:

Clients Name

Last Name:

First Name:

Number of Treatments:

Name of Referring Physician:

Part of Body Treated:

TREATMENT DATES (MONTH/DAY)

WEEK	S	M	T	W	T	F	S
1							
2							
3							
4							
5							
6							

Description of the response to therapy:

Massage Therapist: _____

Signature: _____ Name (please print): _____

Phone Number: ( ) _____ Date: _____

**Treating Massage Therapists must be registered with the Massage Therapists' Association in the province/territory of their practice.*

Head Office: Box 8888 • Yellowknife, NT X1A 2R3 • Telephone: (867) 920-3888 • Toll Free: 1-800-661-0792 • Fax: (867) 873-4596 • Toll Free Fax: 1-866-277-3677
or
Box 669 • Iqaluit, NU X0A 0H0 • Telephone: (867) 979-8500 • Toll Free: 1-877-404-4407 • Fax: (867) 979-8531 • Toll Free Fax: 1-866-979-8501
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