

MAUI ACADEMY OF THE HEALING ARTS SCHOOL OF MASSAGE

310 OHUKAI ROAD, SUITE 318, KIHAI, HI 96753

John Sanderson, M.C., Principal

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Application Form

Name: _____
first middle last

Home Address: _____
Street or P.O. Box number Apt. #

_____ city state zip code

Home phone: _____ Social Security # _____

Email address: _____

Sex: _____ Date of Birth: _____ Age: _____

Emergency Contact: _____ Phone: _____

Current Place of Employment: _____

Address: _____
street city state zip code

Work phone: _____ Occupation: _____

ENTRANCE REQUIREMENTS

- High school diploma or equivalent.
- Minimum age of 18, or written permission from parent or legal guardian.
- No diseases or disabilities that would jeopardize the health and safety of the student or client in fulfilling the training or duties of a massage therapist.
- Personal interview with the Principal.
- \$78.00 non-refundable application fee – Make check payable to SAN CORP.
- Completed Health Evaluation.

FOR OFFICE USE ONLY:

Date Application Received: _____

Date \$78.00 Deposit Received: _____

Date Interview Completed: _____

Date of Admission: _____ Start Date: _____

1. Briefly summarize your education, both formal and informal.
List any degrees obtained.

2. Summarize previous massage training, experience, professional massages received, short trainings, workshops, schools and instructions with **dates** of each.

3. Why do you want to become a Massage Therapist?

4. How do you best learn?

5. Do you have any specific learning difficulties:

- a. verbally (concepts and ideas) _____
- b. visually (sight) _____
- c. auditorally (hearing) _____
- d. kinesthetically (touching or being touched) _____

6. Have you ever been convicted of a felony? _____

HEALTH EVALUATION

3.

This questionnaire will remain strictly confidential and for the sole use of the administrative staff of the Maui Academy of the Healing Arts. The information you provide will help us assess your needs and consult with you appropriately. We are aware that our program is physically, emotionally, and academically demanding and it is important to us that we contribute all we can to your success. **Please complete each of the following:**

1. List any medications taken regularly. _____
2. Do you have any physical limitations? Yes ___ No ___ If yes, please describe: _____

3. Have you ever been treated for emotional disorders? Yes ___ No ___ If yes, please describe: _____

4. Are you presently receiving treatment for any reason? Yes ___ No ___ If yes, please list: _____

5. Do you have any allergies? Yes ___ No ___ If yes, please list: _____
6. Have you had any injuries due to accidents or sports? Yes ___ No ___ If yes, please describe: _____
7. Your primary health care provider: Name _____ Phone _____

Do you have a **present** or **past history** of any of the following conditions? If so, please **circle**.

Alcoholism	Anxiety	Tuberculosis
Back Problems	Chronic Pain	Mumps
Convulsions/Seizures	Depression	Rubella
Ear Trouble/Hearing Loss	Eating Disorder	Head Injury
Hay Fever (recurrent)	Rheumatic Fever	Pneumonia
Hepatitis/Jaundice	Leukemia	High Blood Pressure
Kidney Disease/Trouble	Polio	Cancer
Mononucleosis (infectious)	Asthma	Diabetes
Sinus Trouble	Colitis	Varicose Veins
Joint Disease/Injury	Sleep Problems	Drug Abuse
Eye Disease	Fainting/Blackouts	Heart Disease
Scarlet Fever	Skin Trouble	Measles (red)
Intestinal/Stomach Problems	AIDS	

Other illness, surgery or injury: _____

Your signature below indicates that the information on this form is complete and true to the best of your knowledge. Falsification or omission of any pertinent information on this form or the Application form may be grounds for dismissal.

Name _____ Date _____