

Hospital-Based Massage Therapy for Seriously Ill Patients

Needs Assessment

Hertzberg Palliative Care Institute
Brookdale Department of Geriatrics and Adult Development
Mount Sinai School of Medicine

June 6 - 7, 2009

In preparation for our upcoming educational program on Hospital-Based Massage Therapy Practice, we are asking each participant to take a few minutes to complete the assessment form below. This information will help us to understand your reasons for attending this program, your professional background, experience, learning needs and expectations.

At your earliest convenience, please email or fax return
ATTN - Diane Maguire at (212) 241-5960 or diane.maguire@mssm.edu

1). **Level of massage training or certification:** ___ LMT ___ NCBTMB

comments: _____

2). **Additional degrees or professions:** ___ RN ___ Other (please specify): _____

3). **Years of experience as a massage therapist:**

___ less than 1 yr. ___ 1 - 5 yrs. ___ 5 - 10 yrs. ___ 10 -15 yrs. ___ more than 15 yrs.

4). **Name & location of massage therapy school you attended:** _____

5). **The state(s) and/or country where you currently practice:**

___ NY ___ NJ ___ CT ___ Other, please specify: _____

6). **Setting of practice:** (check all that apply)

___ Private Practice, please indicate area of specialty: _____

___ Cooperate, please indicate where, and area of specialty: _____

___ Chiropractic Office, please indicate area of specialty: _____

___ Institutional Practice

___ Hospital ___ Nursing Home ___ Residential Care Facility ___ Hospice

___ Other, please specify : _____

7). Reasons for attending this program? _____

8). Identify two personal learning objectives:

1. _____
2. _____

9). What are your expectations of this educational program?

10). Additional Comments: _____

Thank you!

**Please email or fax completed form to Diane Maguire, fax # (212) 241- 5960
diane.maguire@mssm.edu**

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http://www.mssm.edu/palliative/massage_therapy.shtml