Massage Therapists' and Wholistic Practitioners' ASSOCIATION OF THE MARITIMES

Course or Program Submission Form

This form must be completed by the member. Please attach any evidence such as certificates, letter of completion, receipts, summary or practice integration of any continuing education.

*NAME:*____ *MTWPAM #:*__________________

To Be Completed by Member				Completed by MTWPAM	
Program or Course (Title/Description/Location)	**Length**	**Credits**	**Date Completed**	**Submission Requirement**	**Credits Verified**

Please send this completed form with your supporting documentation to:

MTWPAM
156 Ochterloney, Unit 201
Dartmouth, NS B2Y 1E1

ATTENTION: MTWPAM CONTINUING EDUCATION

OFFICE USE ONLY

Date received: ____________________ Reviewed by: _________________________________ Date: ________________

Primary credits: __________ Secondary credits: __________

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Self-Evaluation & Practice Integration Form

*Name of Event:*____ *Author/Presenter:*_____________________________________

*Date of Event:*____ *Location:*____

Publication ☐ *Meeting* ☐ ☐ ☐ *Distance / E-Learning* ☐ *Volunteering* ☐

Self-Evaluation & Summary: *Please provide a brief description in full sentences of what you learned.*

Practice Integration: *Please describe how you were able to incorporate what you learned into your practice.*

*NAME:*____ *MTWPAM #:*________________________

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Study Group Participation Form

Member Name: ____ Membership Number: ______________

A separate form must be completed for each study session for credit to be approved.

Study groups must be a minimum of 3 participants. The study material must be consistent with the scope of practice established by MTWPAM, and have significant content directly related to the practice of massage therapy or any of it's modalities that are supported

The following is to be included in your submission

1. Content - must include more than a study title; marketing and promotional literature are not valid course outlines.
2. Format - ex: hands-on practice on other participants; discussion of theory; lecture
3. Study materials - ex: manuals, texts or videos (incl. title and date of publication)
4. Duration and frequency - ex: 1 hour session per month for 6 months; meeting twice a month

Provide written answers to the following:

1. Explain how this study group has been or will be beneficial to your practice.
2. Include at least one relevant, anonymous case history or clinical record to demonstrate the patient/client benefit received specifically and directly as a result of your study group.
3. Any other comments.

*NAME:*____ *MTWPAM #:*_____________

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Teaching/Supervising/Tutoring Form

Member Name: ____ Membership Number: _____________________

Course taught:_______ Supervised:_______ Tutored:_______

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Location and dates of course:

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What are your qualifications:

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Therapist signature: ______________________________________ Total hours: ___________________________

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Mentoring/Shadowing Form

Mentoring is defined as an activity in which a member observes or shadows you in your practice to obtain a better understanding of other modalities or to learn new techniques

Shadowing is defined as an activity in which you may observe or shadow another health professional to obtain a better understanding of other modalities or to learn new techniques. This form is for either activity.

Member Name: ____Membership Number: __________________________

Shadow's:______ Mentor's ______ Name:____

Mentor's or Shadow's Contact Information: ____

Dates of events: ____

____

If shadowing what are the Mentor's Qualifications (profession, credentials, number of years in practice):

____

____

____

Client consent along with a confidentiality agreement are in place prior to mentoring/shadowing

Give a brief description of your observations, learning experiences or what you taught:

____

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____

If more space is needed please use the reverse side.

Therapist signature: ____Total hours of mentoring: ______________

Please submit copies of all documentation to:

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Primary credits: ___________ Secondary credits: ___________

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Case Study Form

Name: ____ Membership Number: _____________

The following information is to be included with a copy of this form to MTWPAM.
Any missing documentation may affect the assessment and CEU credit.

1. Patient history (name not required)
2. Symptoms patient presents with. (reason for visit)
3. Clinical findings. (assessment findings including assessment, range of motion testing, palpation)
4. Treatment provided (give a brief explanation justifying your treatment.)
5. Re-assessment.
6. Follow-up treatments. (how did the patient progress, assessment findings in follow-up treatments)
7. Describe how this case helped your learning process as a therapist and what information you can pass to other therapists if they may encounter a similar situation.

The case study must have at least four (4) treatments in total.

Signed: ____ Date: ___________________

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Primary credits: _________ Secondary credits: _________