MTAS WAIVER / RELEASE

I, _____, acknowledge that _____ (the "Therapist"), in returning to work, has confirmed to me that he/she has adhered to all health standards and guidelines set out by the Government of Saskatchewan relating to COVID 19.

The Therapist has confirmed to me that they have complied with all hygiene and practice standards imposed by the *Massage Therapist Association of Saskatchewan* (MTAS). Notwithstanding the Therapist has complied with Personal Protection Equipment requirements and complies with the appropriate guidelines, the Therapist cannot guarantee there will be no contraction of COVID 19 arising out of treatment.

This form constitutes a release and waiver of the Therapist from liability should COVID 19 be contracted through treatment. I acknowledge I have been requested to execute this release and it is a condition of my receiving treatment from the Therapist, and failure to execute this Waiver and Release may result in treatment being refused.

1. I ACKNOWLEDGE and AGREE I understand the nature of the treatment I have requested.

2. I CONFIRM I am not currently showing any symptoms of COVID 19, and I have not, to my knowledge, contracted COVID 19, and I am aware of the COVID 19 symptoms.

3. I HEREBY RELEASE, WAIVE and DISCHARGE the Therapist, his/her administrators, employees, officers, agents, successors, heirs and assigns from all liability, actions, demands, and proceedings arising from my contracting COVID 19 as a result of my treatment.

4. I ACKNOWLEDGE I have read this Waiver and Release and fully understand its terms and I have signed it freely and without any inducement or assurance of any nature; and I intend it to be a complete and unconditional release of all liability to the greatest extent allowed by law relating to my contracting COVID 19 from treatment. If any portion of this Waiver and Release is held to be invalid, the balance, notwithstanding, shall continue in full force and effect.

This Waiver and Release shall be governed by and construed under the laws of the Province of Saskatchewan.

PRINTED NAME OF PATIENT: _____

PATIENT SIGNATURE AND DATE: _____

PRINTED NAME OF MASSAGE THERAPIST: _____

MASSAGE THERAPIST SIGNATURE AND DATE: _____

MTAS
Massage Therapist Association of Saskatchewan

Supplemental Consent form – COVID-19

- Due to the infectious nature of COVID-19, this additional intake form must be completed before each massage therapy session. Please know that people with COVID-19 can be asymptomatic and still be contagious.
- There is no way to completely protect ourselves from this virus.
- Ask for the checklist of precautions to see how I am disinfecting my clinic between sessions.
- Please answer these questions truthfully and do everything asked so we can do our best to protect each other. Thank you!

1.Testing status.

Have you been tested for COVID? Y/N The antibody? Y/N
When? _____ What were the results? _____

2. Symptoms – are you experiencing:

- Fever >38C? Y/N
- Cough? Y/N
- Sore throat? Y/N
- Shortness of breath? Y/N
- Sudden loss of taste and smell? Y/N
- Fatigue? Y/N
- Chills? Y/N
- Nasal or sinus congestion? Y/N
- Sudden onset unexplained body aches? Y/N

3. Exposure: Are you aware of having been exposed to someone with COVID-19 or anyone who has been exposed to someone with COVID-19? Y/N

4. Travel.

- Have you done any air travel, domestic or international, recently? Y/N
- Have you traveled to any places with a high infection rate, where people have not been isolating (no stay at home order), or been in any groups of people where social distancing was not observed? Y/N

5. Precautions.

What precautions have you taken to limit your exposure to the virus? _____

_____

6. High risk contact.

- Do you spend time around anyone considered high risk, such as elderly with co-morbidities or immunocompromised family members? Y/N

_____

7. Requested Actions

- Are you willing to wash or sanitize your hands upon entering my office and post-massage? Y/N
- Are you willing to wear a face mask at all times in my office and during the treatment? Y/N

Printed name of client: _____

Client signature: _____ Date: _____

Massage therapist signature: _____ Date: _____