

Date \_\_\_\_\_

Patient Name \_\_\_\_\_

\_\_\_\_\_ Health Care Provider

\_\_\_\_\_ Address

\_\_\_\_\_ Telephone

To Tara's Place LLC

Patient (name) \_\_\_\_\_ would benefit from receiving  
Therapeutic massage and/or bodywork treatments at Tara's Place LLC.

Sincerely,

(Health Care Provider signature)

\*This form allows our client to receive massage sales tax free