# Needs Assessment

**Hertzberg Palliative Care Institute**  
Brookdale Department of Geriatrics and Palliative Medicine  
Icahn School of Medicine at Mount Sinai

**April 25-26, 2015**

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.

Please submit along with registration form and payment

| 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:  
| _____Corporate, 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:  

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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!

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This program is sponsored by:

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Brookdale Department of Geriatrics and Palliative Medicine
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