Hospital-Based Massage Therapy for Seriously Ill Patients

**Needs Assessment**

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

June 25-26, 2011

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

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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: ________________________________
   ___ Coperate, 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 submit along with registration form and payment

This program is sponsored by:

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Lilian and Benjamin Hertzberg Palliative Care Institute
Brookdale Department of Geriatrics and Palliative Medicine
Mount Sinai School of Medicine

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