State of Alabama
Department of Public Health

Employer Quarterly Report

Name _____
License Number _____
Date Submitted _____

Report Submitted By

First Name _____ Last Name _____

Phone Number _____ Email Address _____

Employment Details

Date of Employment _____ Establishment License Number _____

Job Description

Do you have a copy of the Department Order? ☐ Yes ☐ No

Case number _____

Hours Massage Therapist Worked

Please enter the actual hours the LMT worked during each month of the quarterly reporting period

Month 1	Month 2	Month 3

Job Performance

	Satisfactory	Unsatisfactory
Overall performance		
Professional behavior		
Relationships with peers/ coworkers		
Relationships with supervisor/ administration		

Other Questions

	Yes	No
Has the LMT been requested to drug screen by the employer in this reporting period?		
Has the LMT been counseled/ written up or disciplined at work this month for any reason?		
Has the LMT reported to work impaired?		
Have you received any complaints about the LMT during this reporting period?		
Has the LMT had any issues with documentation of appointments?		
Has the LMT been terminated from employment during this reporting period?		

Reason for leaving (if applicable) _____

Date last worked _____

Eligible for rehire? ☐ Yes ☐ No

Other comments

By my signature I acknowledge that this licensee has furnished this employing agency with a complete copy of the Order or Agreement containing the above Case Number and can abide by such terms.

Employer Name (Print) _____

Employer Signature _____

Date _____

Please email completed forms to Massage.Therapy@adph.state.al.us

Alabama Department of Public Health
Massage Therapy Program
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(334)206-5373