

Date: _____

Dear ATMS,

This is to certify that _____ has successfully completed the _____ course on campus, and is compliant with the minimum education standards as outlined by the major health funds.

Course start date: _____

Course completion date: _____

The Health Fund educational criteria for Approved Provider status, have been met being as follows:

- a) Qualifications completed full time over 12 months or part time over 18 months (excluding Bachelor of Health Science Myotherapy)
- b) A minimum of 200 supervised clinical hours conducted on campus and supervised by a trainer with appropriate qualifications
- c) Course conducted on campus face to face

20% _____ 50% or more _____

*Please note that completing less than 50% of your course on campus will make you ineligible for ARHG registration.

- d) The following components completed on campus:

- Surface anatomy
- Palpation
- Clinical examination
- Assessment of conditions
- Treatment plans
- Tactile therapies
- Massage/Myotherapy techniques and other associated therapeutics and techniques

Name: _____

Signature: _____ Position: _____