MTAS WAIVER / RELEASE

I, _____, acknowledge that _____ (the “Therapist”), in returning to work, has confirmed to me that he/she has adhered to all health standards and guidelines set out by the Government of Saskatchewan relating to COVID 19.
The Therapist has confirmed to me that they have complied with all hygiene and practice standards imposed by the Massage Therapist Association of Saskatchewan (MTAS).
Notwithstanding the Therapist has complied with Personal Protection Equipment requirements and complies with the appropriate guidelines, the Therapist cannot guarantee there will be no contraction of COVID 19 arising out of treatment.

This form constitutes a release and waiver of the Therapist from liability should COVID 19 be contracted through treatment. I acknowledge I have been requested to execute this release and it is a condition of my receiving treatment from the Therapist, and failure to execute this Waiver and Release may result in treatment being refused.

1. I ACKNOWLEDGE and AGREE I understand the nature of the treatment I have requested;

2. I CONFIRM I am not currently showing any symptoms of COVID 19, and I have not, to my knowledge, contracted COVID 19, and I am aware of the COVID 19 symptoms.

3. I HEREBY RELEASE, WAIVE and DISCHARGE the Therapist, his/her administrators, employees, officers, agents, successors, heirs and assigns from all liability, actions, demands, and proceedings arising from my contracting COVID 19 as a result of my treatment.

4. I ACKNOWLEDGE I have read this Waiver and Release and fully understand its terms and I have signed it freely and without any inducement or assurance of any nature; and I intend it to be a complete and unconditional release of all liability to the greatest extent allowed by law relating to my contracting COVID 19 from treatment. If any portion of this Waiver and Release is held to be invalid, the balance, notwithstanding, shall continue in full force and effect.

This Waiver and Release shall be governed by and construed under the laws of the Province of Saskatchewan.

PRINTED NAME OF CLIENT:_____

SIGNATURE AND DATE: _____

PRINTED NAME OF MASSAGE THERAPIST: _____

MASSAGE THERAPIST SIGNATURE AND DATE: _____

_____
I certify that the above information has not changed since the original date of signature.

Patient Signature: _____ RMT initials: _____ Date: _____

Patient Signature: _____ RMT initials: _____ Date: _____

Patient Signature: _____ RMT initials: _____ Date: _____