



HAWAII ELECTRICIANS HEALTH & WELFARE FUND

1935 HAU STREET, ROOM 300 • HONOLULU, HAWAII 96819-5003 • PHONE (808) 841-6169 • FAX (808) 842-4281

MASSAGE THERAPIST PROVIDER CERTIFICATION

Provider Name (Please print)

Name of Massage Therapy Establishment

Address

Telephone Number

Fax Number

I certify that I am a licensed Massage Therapist in the State of Hawaii and meet all of the following requirements:

1. I have a current State of Hawaii Massage Therapist License;

License No.

Expiration Date

2. I have a current State of Hawaii General Excise Tax License;

License No.

Expiration Date

Federal ID No.

Expiration Date

3. I provide services in a "massage therapy establishment" as defined under the Hawaii Revised Statutes (HRS) Chapter 452-3; and,

Establishment No.

Expiration Date

4. I am a therapist who has been in practice as a full-time licensed massage therapist for a minimum of two (2) years.

I hereby certify that all of the above information is true and correct. I understand that the Trust Agreement, policies and the rules and regulations adopted by the Board of Trustees are the final authorities in all matters related to the Hawaii Electricians Health & Welfare Fund.

Provider's signature

Date