



Rode Kruis  
Vlaanderen

## Certificate of therapeutic needle treatment

I, the undersigned, hereby declare

- (1) That I have performed acupuncture/dry needling/myofascial therapy/another therapeutic treatment using needles (please specify):

.....

on Mr/Mrs/Miss:.....

date of birth:.....

on .....(date of the therapeutic needle treatment).

- (2) that I am affiliated with BAF/ABADIC/EUFOM/BMST or possess a certificate from

a course completed at .....

- (3) that I work in compliance with the standards applicable to an aseptic technique: including skin disinfection and the single use of disposable sterile materials.

- (4) that no products were injected.

Therapist's surname and first name: .....

Address: .....

Telephone number:.....

Authorisation number:.....

Date .....

Stamp and signature

