



**Rode Kruis
Vlaanderen**

Medisch Secretariaat

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Certificate of therapeutic needle treatment

I, the undersigned, hereby declare

(1) that I have applied acupuncture/dry needling/myofascial therapy/
another therapeutic needle treatment (to be specified):

.....

to:

born on:

on(date of the therapeutic needle treatment).

(2) that I am affiliated with BAF/ABADIC/EUFOM/BMST/have a certificate from
a training course followed at

(3) that work is carried out in accordance with the applicable standards of aseptic
technique, using sterile disposable materials.

(4) that no products were injected.

First and last name of therapist:

Street + number:

Municipality:

Phone number:

Certification number:

Date:

Stamp and signature