CONSULTING PHYSICIAN AGREEMENT FORM

THIS IS TO CERTIFY THAT THE UNDERSIGNED HAS READ AND ARE FAMILIAR WITH THE MEDICAL PRACTICE ACT RULES AND REGULATIONS PERTAINING THERETO. THIS AGREEMENT ALSO ATTESTS TO FOLLOW ALL SAFETY PROCEDURES AND RULES, AS STATED IN THE OFFICE SAFETY PROTOCOL.

SENIOR LASER PRACTITIONER INFORMATION

_____

Senior Laser Practitioner Name (PRINT)

_____ _____

Senior Laser Practitioner Signature **DATE**

CONSULTING PHYSICIAN INFORMATION

The agreement must include contact information for the consulting physician in the event of problems that may arise.

_____ _____

Consulting Physician Name (PRINT) **LICENSE #**

_____ _____

Consulting Physician Signature **DATE**

_____ _____

Consulting Physician Address

_____ _____

City **State** **Zip Code**