Aesthetic Extender Symposium

Physician Authorization Form

Acknowledgement and Authorization for Hands-On Training

I attest by my signature that I am the supervising physician for _____ and that he/she practices under my supervising authority as a licensed (select one):

☐ PA ☐ NP ☐ RN ☐ Other: _____

I hereby confirm that I am aware that _____ is participating in an instructional course on the proper administration of:

☐ Dermal Fillers

I further understand he/she will be providing patient treatment during the hands-on portion of the course. I understand and give my permission, as the supervising physician, that the treatments will be provided by _____and will be performed outside of my presence but their model has been evaluated by me and cleared for these procedures.

PRINT:

_____

Practice Name

_____

Practice Address

_____

Supervising Physician – Please Print Name/Credentials *(if applicable, i.e. NP working autonomously)*

_____

Supervising Physician Signature *(if applicable, i.e. NP working autonomously)*

_____

Date

Email completed form to info@aestheticextendersymposium.com within 1 week of registration to confirm your seat. If forms are not received within 1 week, your registration will not be confirmed.