



Physician Authorization Form

This form must be completed by each PA, NP, or RN registering for an Aesthetic Advancements course.

Aesthetic Advancements, Inc.
2700 Braselton Hwy, Suite 10-450
Dacula, Georgia 30019

RE: Acknowledgement and Authorization for Hands-On Training Please complete for each PA, NP, or RN registering.

I attest by my signature that I am the supervising physician for _____ and that he/she practices within my facility 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:

Neurotoxins (BoNTA)/Dermal Fillers

Sclerotherapy

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

Aesthetic Liaison: Anne Marie Camp Phone: (770) 365-3319 Fax: (888) 205-1434