

**MEDICAL DIRECTOR ACKNOWLEDGEMENT STATEMENT**  
**(CHIROPRACTOR)**

I, \_\_\_\_\_, am the designated **Medical Director** of  
*(Print Name) (Title)*

\_\_\_\_\_. I am:  
*(Facility Name)*

- a. A licensed practitioner of the healing arts, qualified to perform these procedures in accordance with my scope of practice as defined by my licensing board.
- b. The licensed practitioner establishing written protocol procedures for each laser use.
- c. The licensed practitioner with the prescribing authority to perform therapeutic procedures with prescriptive devices. (Class 3b or 4 lasers and Class 2 R-F).
- d. Available to provide required functions.

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*