SUPERVISING PRESCRIBING HEALTH PROFESSIONAL APPROVAL LETTER

As Medical Director of _____, **I,** _____**,** certify that I was the
(Name of Facility) **(Name of Current Medical Director)**

hands-on instructor and present in the room during _____'s 24 hours of
(Print Name of Laser Trainee)

hands-on laser and/or IPL hair reduction training and has performed a minimum of 10 treatments. I have verified that _____ has completed the training and supervision per
(Print Name of Laser Trainee)

A.R.S. §§32-516 and/or 32-3233.

I also certify that I was the hands-on instructor and present in the room during

_____'s 24 hours of hands-on laser and/or IPL training for other cosmetic
(Print Name of Laser Trainee)

procedures and performed in a minimum of 10 treatments of the below listed modalities. I have verified that _____ has completed the additional training and supervision per
(Print Name of Laser Trainee)

A.R.S. §32-516 and/or §32-3233.

ONLY CHECK THE MODALITIES/PROCEDURES YOU ARE APPLYING FOR

MODALITY/PROCEDURE

- ☐ Hair Reduction
- ☐ Spider Vein Reduction
- ☐ Skin Rejuvenation
- ☐ Non-Ablative Skin Resurfacing
- ☐ Skin Tightening
- ☐ Wrinkle Reduction
- ☐ Telangiectasias

MODALITY/PROCEDURE

- ☐ Laser Peel
- ☐ Acquired Adult Hemangiomas
- ☐ Facial Erythema
- ☐ Acne Scar Reduction
- ☐ Solar Lentigos Reduction (Age Spots)
- ☐ Ephelis Reduction (Freckles)
- ☐ Photofacial
- ☐ Other: _____

_____
Print Name of Medical Director

_____
Signature of Medical Director

_____
Date