Dear Physician,

The patient named below has applied to receive a professional skin care treatment. This is a superficial restorative skin care treatment to help build up the health of the skin by using only safe, non-invasive skin care ingredients and protocols. The skin care treatment will be performed by a professional licensed skin care therapist who has been trained and certified in oncology skin care. We have consulted with the client on any allergies, sensitivities, and appropriate skin care concerns. The skin treatment will be performed in a clean, safe, and disinfected environment.

Please fill out, sign and returned this form to the address or fax below. If you have any questions, please feel free to call us directly. Thank you.

Client's Name:_____
Business Name:_____
Address:_____
Phone:_____
Email:_____

Licensed Skincare Therapist:_____
License No. _____

Office Only

❑Allergies_____
❑Physical Restrictions and/or Needs_____

I believe that the above-named patient is a reasonable candidate to participate in receiving a professional skincare treatment to the business and therapist listed above.

Physician Signature _____ Print _____
Clinic Practice _____ Phone _____