

SUPERVISING HEALTH PROFESSIONAL APPROVAL LETTER

If technicians were trained by previously employed Medical Director other than their current Medical Director and are requesting a Supervising Health Professional's letter of Approval from their current Medical Director, the verbiage should be stated as such:

As Medical Director of _____, I, _____, certify that
(Name of Facility) (Print Name of Current Medical Director)

_____ was the hands-on instructor and present in the room during
(Print Name of Supervising Health Professional)

_____ 's 24 hours of hands-on laser and/or IPL hair reduction training and has
(Print Name of Laser Trainee)

performed a minimum of 10 treatments, based on past and present records kept by

_____. These records will be available for Arizona Radiation Regulatory
(Name of Laser Training Facility)

Agency's review upon request. Based on these records, I verify that _____ has
(Print Name of Laser Trainee)

completed the training and supervision per A.R.S. §§32-516 and/or 32-3233.

I also certify that _____ was the hands-on instructor and present in the
(Print Name of Supervising Health Professional)

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

cosmetic procedures and performed in a minimum of 10 treatments of the below listed modalities.

based on past and present records kept by _____. These records will be
(Print Name of Training Facility)

available for Arizona Radiation Regulatory Agency's review upon request. Based on these records, I

verify 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

Specify the **unit used** for each **modality/procedure**
(Example: **Laser Hair Removal – IPL, Laser and/or RF**)

<u>MODALITY/PROCEDURE</u>	<u>UNIT USED</u>	<u>MODALITY/PROCEDURE</u>	<u>UNIT USED</u>
<input type="checkbox"/> Hair Reduction	_____	<input type="checkbox"/> Laser Peel	_____
<input type="checkbox"/> Spider Vein Reduction	_____	<input type="checkbox"/> Acquired Adult Hemangiomas	_____
<input type="checkbox"/> Skin Rejuvenation	_____	<input type="checkbox"/> Facial Erythema	_____
<input type="checkbox"/> Non-Ablative Skin Resurfacing	_____	<input type="checkbox"/> Acne Scar Reduction	_____
<input type="checkbox"/> Skin Tightening	_____	<input type="checkbox"/> Solar Lentigos Reduction (Age Spots)	_____
<input type="checkbox"/> Wrinkle Reduction	_____	<input type="checkbox"/> Ephelis Reduction (Freckles)	_____
<input type="checkbox"/> Telangiectasias	_____	<input type="checkbox"/> Photofacial	_____
		<input type="checkbox"/> Other: _____	

Signature of Medical Director

Signature of Supervising Health Professional

Date

Date