

**SUPERVISING 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**  
 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: _____	

\_\_\_\_\_  
**Print Name of Medical Director**

\_\_\_\_\_  
**Signature of Medical Director**

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