

SUPERVISING LASER TECHNICIAN LETTER OF APPROVAL

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

_____ is an Arizona Radiation Regulatory Agency certified supervising
(Print Name of Supervising Laser Technician)

laser technician and was the hands-on instructor and present in the room during

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

has performed a minimum of 10 treatments. I have verified 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 that _____ is an Arizona Radiation Regulatory Agency
(Print Name of Supervising Laser Technician)

certified supervising laser technician and was the hands-on instructor and present in the room

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

performed in a minimum of 10 treatments of the below listed modalities. I have verified that

_____ has completed the additional training and supervision per A.R.S.
(Print Name of Laser Trainee)

§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 ARRA Certified Supervising Laser Technician

 Date

 Print Name of Medical Director

 Signature of Medical Director

 Date