

★ PHYSICIAN ACKNOWLEDGEMENT FORM ★

To be Filled Out by the Client

Client's Name _____
Street Address _____
City _____ State _____ Zip Code _____
Telephone Number _____
Date of Birth _____
Piercing to be Performed _____
Condition (if any) that may affect my piercing _____

To be Filled Out by Physician

Physician's Name _____
Street Address _____
City _____ State _____ Zip Code _____
Physician's Telephone _____

I, the physician of the above patient, understand that the patient intends to have a body piercing performed at the Museum of Living Arts. As the patient's physician I am aware of the above listed condition and am willing to treat the patient should any complications arise.

My willingness to treat the patient, should a problem arise, is in no way an endorsement of the practice of body piercing.

Physician's Signature _____ Date _____