



MONITORING PHYSICIAN'S STATEMENT

The undersigned monitoring physician acknowledges that he/she has read and understood the attached Consent Order and agrees to serve as monitoring physician for

(Name of subject licensee)

Sworn to and subscribed before me
this ____ day of _____, 20____.

NOTARY PUBLIC

(SEAL)

My Commission Expires_____

Telephone #:_____

Name (please print)

Physician Signature

Program:_____

Address:_____

License #:_____