Georgia Board of Dentistry

2 Peachtree Street, N.W., 6th Floor
Atlanta, GA 30303

(404) 651-8000 www.gbd.georgia.gov

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____.	_____________________________________ Name (please print)
_________________________________ NOTARY PUBLIC	_____________________________________ Physician Signature
(SEAL)	Program:______________________________
	Address:______________________________
My Commission Expires_____________	_____________________________________
Telephone #:______________________	License #:_____________________________