



**GEORGIA BOARD OF DENTISTRY  
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 #: \_\_\_\_\_