

University of Florida Continuing Dental Education
Botulinum Toxin Patient Authorization Form

Name (Please Print): _____

Date: _____

I authorize _____ / I do not authorize _____ the administration of Botulinum Toxin to me by a course participant.

I understand the known risks and side effects and they have been explained to me. This procedure is being performed in conjunction with the continuing education program entitled "**Botulinum Toxin: The HOW & WHY to Incorporate it into Your Dental Practice**" under the direction of Dr. Tracy Shaw Blessing. Any inquiries concerning the procedure have been answered to my satisfaction.

I confirm that, to the best of my knowledge, I am in good health and without medical problems or conditions contraindicated to Botulinum Toxin.

I understand that I may withdraw my consent at any time without prejudice.

I also understand that all data collected will remain confidential.

I have read and understand the above-described procedure.

Participant Signature: _____

Witness Signature: _____

Witness Name (Please Print): _____