Piercing Physician Acknowledgement Form

To Be Filled Out By Client:

Client Name____

Parent and/or Guardian____

Street Address____

City ___________________________ Prov ____________ Postal Code ______________________

Telephone h:(______)____________________________c:(______)___________________________

Date of Birth (2000-12-01) ___________________________

Piercing To Be Performed ____

Condition which may affect healing of Piercing ____

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I have read all aftercare instructions associated with Piercing and have had the opportunity to ask all questions associated with this Piercing. I understand that infection may be a risk associated with Piercings and the above listed condition, if applicable, may further increase the chance of infection or complications during the healing process.

Client Signature _____________________________ Date ________________________________

To Be Filled Out By Physician:

Physician Name ____

Street Address____

City_________________________ Prov_____________Postal Code _________________________

Physician's Telephone Number: (______)____

I, the physician of the above patient, understand that the patient intends to have a Body Piercing, performed at Westcoast Piercing and Ink. I am aware of the above listed condition, if applicable and am willing to treat the patient should any complications arise.

My signature is not an endorsement of the practice of Body Piercing.

Physician's Signature_______________________ Date ____________________________________