Prosperity DENTAL SOLUTIONS
LOVE YOUR PRACTICE, LOVE YOUR LIFE
ONCE THE CLOSER, NOW THE COACH ™

Clearance to Shadow for Training

I, (Patient First & Last Name Printed: _____,
agree that for the purposes of the dental practice's ability to better train their new team member, I will allow said team member: (Team Member First & Last Name Printed): _____, to be in the room during my dental procedure. I understand that the office has taken all proper precautions necessary, such as said team member wearing proper PPE and maintaining proper distancing, to safely have this team member in the operatory while I receive my treatment.

I have been given the opportunity to ask any questions I may have prior to the team member coming in to view my procedure:(YES / NO).

Patient Name: _____ Date: _____
Relationship to Patient: _____
Signature: _____
Rendering Provider Name Printed: _____
Rendering Provider Signature: _____ Date: _____