DERMATOLOGY

Physician name: ______________________________ CPSID: __________

Facility applying to: ______________________________

Please indicate only the procedures you wish to perform at the above-mentioned facility.

- ☐ Curettage electrosurgery, skin carcinoma
- ☐ Moh's micrographic surgery
- ☐ Skin lesions – special therapy

I hereby certify that the procedures selected in this application are within the scope of my current practice.

Physician signature: ______________________________ Date: ______________