PANACEA
PLASTIC SURGERY

Kimberly Singh, M.D. I Nour Abboushi, M.D

901 Bernina Ave NE Unit 1 Atlanta GA 30307
P: 770.929.0634 F: 770.929.8716

Patient:_____ D.O.B: _____

The above named patient is scheduled for a:_____
_____, with Dr. _____,
please indicate if this patient:

( ) Is medically cleared for surgery.

( ) Is NOT medically cleared for surgery.

Comments/Additional Notes:
_____
_____
_____
_____

WE DO NOT HAVE ANY SPECIFIC REQUIREMENTS FOR MEDICAL CLEARANCE & WILL LEAVE THIS UP TO YOUR DISCRETION

Physician Printed Name: _____

Physician Signature:_____

Date:_____

IF YOU ARE A MID LEVEL PROVIDER WE WILL ALSO NEED YOUR SUPERVISING MD's SIGNATURE

MD Printed Name:_____

MD Signature:_____

Date:_____

MEDICAL CLEARANCE FORMS ARE ONLY VALID FOR 30 DAYS

****WE DO NOT HAVE ANY SPECIFIC MEDICAL CLEARANCE REQUIREMENTS****
*****WE LEAVE THIS UP TO THE DOCTORS/ PHYSICIANS DISCRETION*****

Please fax completed and signed clearance to: **770.929.8716**