

Dr Dagmar Whitaker

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Dermatologist / Dermatoloog

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CONSENT FOR PROCEDURES

I _____ I.D. Number : _____

Hereby consent to any procedures deemed necessary by Dr Whitaker, i.e. Cryotherapy, biopsies, excision of lesions, Photo Dynamic Therapy (PDT) – after discussing these procedures with Dr Whitaker.

Date : _____

Name : _____

Signature : _____