FTI DENTAL LAB
The Precision Decision

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REMOVABLE LABORATORY WORK AUTHORIZATION FORM

Doctor: _____

State Lic. #: _____

Address: _____

City: _____ State: _____

Rx Date: _____

Patient: _____

Restoration: _____

Shade: _____

Mould: _____

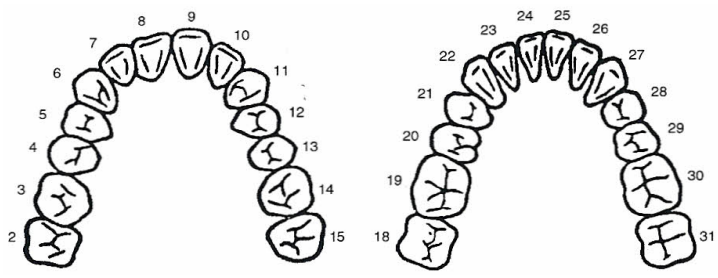
Material: _____

Date Wanted:

Try In: _____

Finish: _____

DESIGN CASE HERE:



INSTRUCTIONS:
Please print or write legibly and make instructions as complete as possible. Use reverse side if necessary.

Signature: _____ D.M.D. / D.D.S.

A COPY OF THIS FORM MUST BE RETAINED BY THE DENTAL OFFICE AND THE DENTAL LABORATORY FOR A PERIOD OF TWO YEARS.

Please Send:	Rx's	BOXES	MAILING LABELS