



MFAS

## MICHIGAN FACIAL AESTHETIC SURGEONS

Facial Plastic and Reconstructive Surgery  
[www.michiganfacialsurgeons.com](http://www.michiganfacialsurgeons.com)

### PRE-OP INSTRUCTIONS – GENERAL

#### PATIENT NAME:

IF YOU NEED TO CONTACT THE SURGERY CENTER FOR ANY REASON PRIOR TO YOUR SURGERY,  
YOU MAY REACH US AT (248) 415-1210. PLEASE DO NOT HESITATE TO CALL.

#### 10 DAYS PRIOR TO SURGERY

- ▶ **STOP SMOKING:** Smoking reduces circulation to the skin and impedes healing (this is especially important if having a facelift).
- ▶ **DO NOT TAKE ANY ASPIRIN OR ASPIRIN CONTAINING MEDICATIONS **for ten days before and ten days after surgery:**** Carefully review the list of drugs to avoid provided for you. Such medications may cause bleeding during and after surgery. Instead, use medications containing acetaminophen (such as Tylenol). Check with your physician regarding administration of antidepressants, diuretics, other routine medications, or any herbal or homeopathic medications you may be taking.

#### DAY BEFORE SURGERY:

- ▶ **PRESCRIPTIONS:** Ensure that all of your prescriptions have been filled before the day of surgery.
- ▶ **DO NOT EAT OR DRINK ANYTHING AFTER MIDNIGHT THE DAY BEFORE YOUR SURGERY. EATING OR DRINKING ANYTHING AFTER THE SPECIFIED TIME MAY RESULT IN CANCELLATION OF YOUR SURGERY.** This includes water, coffee, tea, juice, etc.

#### DAY OF SURGERY

- ▶ **MEDICATIONS:** If instructed to continue your daily medication regime, take your medication with only a sip of water. THE MINIMUM AMOUNT OF WATER NECESSARY IS ALL YOU SHOULD DRINK, It is not necessary to take your antibiotic or multivitamin the morning of surgery.
- ▶ **MAKE-UP:** Please do not wear moisturizers, creams, lotions, eye make-up or other type of make-up.
- ▶ **CLOTHING:** Wear only comfortable, loose-fitting clothing that either buttons or zips in the front. Remove hairpins, wigs, contacts and jewelry. Please do not bring any valuables with you.
- ▶ **CONTACTS:** Please do not wear your contacts the day of surgery, wear your glasses to the Center. If you wear your contacts in please bring a container and the necessary solution for them.

By signing below, I acknowledge that the above has been explained to me and I understand the contents of this instruction page.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## YOUR RIGHTS AND RESPONSIBILITIES AS A PATIENT

YOUR WELL BEING AND HEALING ARE OUR PRIMARY CONCERN AND WE BELIEVE THAT A POSITIVE SURGICAL EXPERIENCE IS A RESPONSIBILITY THAT IS SHARED BY YOU AND OUR STAFF.

### YOUR RIGHTS:

- ▶ You have the right to request and receive information on patient rights, responsibilities and ethics
- ▶ You have the right to request and receive considerate and respectful care that recognizes your cultural, psychosocial, spiritual and personal values, beliefs and preferences.
- ▶ You have the right to request an identified surrogate decision-maker, as allowed by law when you cannot make decisions about your own care, treatment and service.
- ▶ You, your family and/or surrogate decision maker have the right to request, and as appropriate and allowed by law, to be involved in care, treatment, and service decisions , including the assessment and treatment of your pain.
- ▶ You have the right to request an environment that preserves dignity and contributes to a positive self image, including room accommodations as medically appropriate and available.
- ▶ You have the right to request and receive privacy and confidentiality.
- ▶ You have the right to request visitor services as appropriate within the surgical center setting.
- ▶ You have the right to request qualified medical interpretation services, free of charge, if you have special communication needs due to vision, speech, hearing, language or cognitive barriers or impairments.
- ▶ You have the right to request, in a timely manner, the name of the physician primarily responsible for your care, treatment and services and the physician performing your care, treatment and services.
- ▶ You have the right to consult with another physician or specialist, including a pain specialist.
- ▶ You have the right to request informed consent for care, treatment and services provided to you, including the right to refuse to participate in research programs and the recording or filming of your procedure for internal/external purposes.
- ▶ You have the right to withdraw consent for care, treatment and services provided including the consent to participate in a research project or filming or recording of your procedure.
- ▶ You and when appropriate your family have the right to request to be informed about the outcomes of care, treatment and services including unanticipated outcomes.
- ▶ You have the right to freely voice complaints and recommend changes without being subject to coercion, discrimination, reprisal or unreasonable interruption of care, treatment or services.
- ▶ You have the right to request an itemized and detailed explanation of Surgery Center Charges for services rendered and to be provided with financial counseling free of charge, as appropriate.

### IMPORTANT PHONE NUMBERS

Michigan Facial Aesthetic Surgeons - (248) 415 - 0210

## YOUR RESPONSIBILITIES AS A PATIENT

- ▶ Provide to the best of your knowledge, accurate and complete information about your health history, current condition and current medication.
- ▶ Ask questions if you do not understand any aspect of your care, treatment or services provided for you.
- ▶ Cooperate with your doctor, nurse or other caregivers.
- ▶ Follow the written and verbal instructions given to you by your doctor and the nurses.
- ▶ Report changes in your condition or anything you think might be a risk to you
- ▶ Ask the doctor or nurse what to expect regarding the pain you might experience post operatively.
- ▶ Take responsibility for the outcome if you decline or refuse to follow the recommended guidelines and instructions you are given.
- ▶ Show respect and consideration for others.
- ▶ Fulfill the financial obligations of receiving care, including accepting financial responsibility for any consultations with other specialists.
- ▶ Request interpretation services when necessary.
- ▶ Accurately report any allergies to your physician and his staff
- ▶ Be sure you understand any prescriptions given to you-what the medication is for and how you should take it
- ▶ Ask questions about any new medications prescribed for you.
- ▶ Clarify and verify with your surgeon what surgery is to be done and what the expected outcomes will be.
- ▶ Research the surgery you are scheduling and ask questions to clarify any questions you may have
- ▶ Speak up if you have any questions or concerns-all your questions should be answered prior to your surgery

**CONSENT FOR:  
RIDE HOME AND POST OP CARE**

**Patient Name:** \_\_\_\_\_

I understand that I will need someone to drive me home the day of surgery.

**Driver's Name:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

I understand that a responsible adult will need to stay with me for 24 hours following my surgery.

After surgery I will be staying at:

**Home** \_\_\_\_\_

**Hotel** (name) \_\_\_\_\_

**Other** (name) \_\_\_\_\_

**Caretaker's Name:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

I also understand that if a condition arises during my surgery and the operating surgeon feels that admission to the hospital is best for my recovery, I will be admitted as an inpatient following my surgery.

**Patient Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Witness Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

# MEDICATION AVOIDANCE LIST

**HERBAL SUPPLEMENTS AND ALL ASPIRIN AND IBUPROFEN MEDICATIONS ARE TO BE DISCONTINUED 10-14 DAYS PRIOR TO SURGERY**

## **SUPPLEMENTS THAT MUST BE DISCONTINUED**

**VITAMIN E  
BILBERRY  
DONG QUAI  
ECHINACEA  
FISH OIL CAPS  
FEVERFEW  
GARLIC**

**GINGER  
GINKGO BILOBA  
GINSENG  
HAWTHORNE  
KAVA KAVA  
LICORICE ROOT  
MA HUANG(EPHEDRA)**

**MELATONIN  
RED CLOVER  
ST. JOHN'S WORT  
VALERIAN  
CAYENNE  
YOHIMBE**

## **ASPIRIN AND IBUPROFEN PRODUCTS TO BE DISCONTINUED 10-14 DAYS PRIOR TO SURGERY**

- ▶ 4-Way Cold Tablets
- ▶ ASA Tablets
- ▶ ASA Enseals
- ▶ Adult Analgesic Pain Reliever
- ▶ Alka-Seltzer Plus Cold Medicine Tablets
- ▶ Alka-Seltzer Effervescent Tablets
- ▶ Alka-Seltzer Anacin Tablets and Capsules, Max. Strength
- ▶ Anacin with ASA
- ▶ Analval
- ▶ Anodynos
- ▶ Anodynos Tablets
- ▶ Apac Improved
- ▶ APC
- ▶ Argesic Tablets
- ▶ Arthritis Pain Formula
- ▶ Arthralgen Tablets
- ▶ Arthritis Pain Formulas Tablets
- ▶ Arthritis Strength Bufferin Tablets
- ▶ Arthropan Liquid
- ▶ ASA
- ▶ Ascripton A/D Tablets
- ▶ Ascripton
- ▶ Ascripton with Codeine Tablets
- ▶ Asperbuf Tablets
- ▶ Aspercin
- ▶ Aspergum
- ▶ Aspermin
- ▶ Aspirin with Codeine
- ▶ Aspirin Suppositories
- ▶ Aspiatab
- ▶ Axotal
- ▶ Axotal Tablets
- ▶ Azdone Tablets
- ▶ B-A-C Tablets
- ▶ Bayer Timed-Release Aspirin Tablets
- ▶ Bayer's Children's Cold Tablets
- ▶ Bayer Children's Aspirin Tablets
- ▶ Bayer Aspirin Tablets
- ▶ Bayer Aspirin
- ▶ BC Tablet and Powder
- ▶ BC Tablets
- ▶ BC Powder
- ▶ Buf-tabs
- ▶ Buff-A Comp Tablets and Capsules
- ▶ Buffaprin Tablets
- ▶ Buffaprin
- ▶ Buffasal
- ▶ Bufferin, Arthritis Strength Tablets
- ▶ Bufferin, Extra Strength Tablets
- ▶ Bufferin
- ▶ Bufferin with Codeine no. 3 Tablets
- ▶ Bufferin Tablets
- ▶ Buffets II
- ▶ Buffets II Tablets
- ▶ Buffex
- ▶ Buffinol Tablets
- ▶ Buffinol
- ▶ Butalbital
- ▶ Cama Arthritis Pain reliever
- ▶ Carisoprodal Compound Tablets
- ▶ Children's Aspirin
- ▶ Congesprin Chewable Tablets
- ▶ Cope Tablets
- ▶ Cope
- ▶ Coricidin Tablets
- ▶ Coricidin Demilets Tablets for Children
- ▶ Coricidin Medilets Tablets for Children
- ▶ Coricidin 'D' Decongestant Tablets
- ▶ Cosprin 650 Tablets
- ▶ Cosprin 325 Tablets
- ▶ CP-2 Tablets
- ▶ Damason-P
- ▶ Darvol with ASA Polvules
- ▶ Darvon Compound
- ▶ Darvon Compound-65
- ▶ Darvon with ASA
- ▶ Darvon Compound Pulvules
- ▶ Darvon Compound-65
- ▶ Darvon N with ASA
- ▶ Dasin Capsules
- ▶ Dasin
- ▶ Dinol Tablets
- ▶ Disalcid Capsules
- ▶ Doan's Pills
- ▶ Dolcin
- ▶ Dolprn#3 Tablets
- ▶ Double A Tablets
- ▶ Drinophen
- ▶ Dristan
- ▶ Duoprin Capsules
- ▶ Duoprin S-Syrup
- ▶ Duradyne
- ▶ Durasal Tablets
- ▶ Dynosal Tablets
- ▶ Easprin
- ▶ Ecotrin
- ▶ Ecotrin Tablets
- ▶ Efficin Tablets
- ▶ Emagrin
- ▶ Emagrin Tablets
- ▶ Empirin
- ▶ Empirin with Codeine Tablets
- ▶ Empirin with codeine
- ▶ Empirin Tablets
- ▶ Emprazil
- ▶ Equagesic
- ▶ Equagesic Tablets
- ▶ Equazine-M
- ▶ Excedrin
- ▶ Excedrin Tablets & capsules
- ▶ Fedrazil
- ▶ Fiogesic Tablets
- ▶ Fiogesic
- ▶ Fiorgen PF
- ▶ Fiorinal tablets

- ▶ Fiorinal with Codeine
- ▶ Gaysal-S Tablets
- ▶ Gelpirin Tablets
- ▶ Gemnisin Tablets
- ▶ Gemnisyn
- ▶ Genprin
- ▶ Gensan
- ▶ Goody's Headache Powder
- ▶ Goody's Extra Strength
- ▶ Isollyl
- ▶ Isollyl Improved
- ▶ Lanorinal Tablets
- ▶ Lanorinal
- ▶ Lorotab ASA
- ▶ Lortab ASA
- ▶ Magan Tablets
- ▶ Magnaprin
- ▶ Magsal Tablets
- ▶ Marnal
- ▶ Marnal Capsules
- ▶ Maximum Bayer Aspirin
- ▶ Measurin
- ▶ Measurin tablets
- ▶ Meproamate and Aspirin
- ▶ Micrainin
- ▶ Micranin Tablets
- ▶ Midol Original
- ▶ Midol for Cramps Extra Strength
- ▶ Midol Caplets
- ▶ Mobidin Tablets
- ▶ Mobigesic Tablets
- ▶ Momentum Muscular Backache Formula
- ▶ Neocylate Tablets
- ▶ Neogesic
- ▶ Norgesic Tablets
- ▶ Norgesic Forte Tablets
- ▶ Norgesic Forte
- ▶ Norgesic
- ▶ Norwich ES ASP
- ▶ Orhenagesic Forte
- ▶ Orphenagesic
- ▶ OS-CAL-GESIC Tablets
- ▶ Oxycodone and Aspirin
- ▶ P-A-C
- ▶ Pabalate
- ▶ Pabalate-SF Tablets
- ▶ Pabirin Buffered Tablets
- ▶ Pacaps
- ▶ Pain Reliever Tablets
- ▶ Panalgesic
- ▶ Panodynes
- ▶ Pepto-Bismol
- ▶ Percodan
- ▶ Percodan-Demi Tablets
- ▶ Percodan Demi
- ▶ Persistin
- ▶ Phenetron Compound
- ▶ Presalin
- ▶ Propoxyphene Compound 65
- ▶ Propoxyphene Napsylate
- ▶ Propoxyphene Compound
- ▶ Quiet World Analgesic/Sleeping Aid
- ▶ Quiet World Tablets
- ▶ Robaxisal Tablets
- ▶ Roxiprin Tablets
- ▶ S-A-C Tablets
- ▶ Salabuff
- ▶ Salatin
- ▶ Saletto Tablets
- ▶ Saletto
- ▶ Salocol Tablets
- ▶ Salocol
- ▶ Sine-Off Sinus Medicine Tablets
- ▶ Sine-Off Sinus Medicine Tablets-Aspirin Formula
- ▶ SK-65 Compound Capsules
- ▶ Soma Compound Tablets
- ▶ Soma Compound Tablets with Codeine
- ▶ St. Joseph
- ▶ St. Joseph Cold tablets for Children
- ▶ Stanback Tablets and Powder
- ▶ Supac tablets
- ▶ Supac
- ▶ Synalgos Capsules
- ▶ Synalgos-DC Capsules
- ▶ Talwin Compound Tablets
- ▶ Talwin Compound
- ▶ Tenol-Plus
- ▶ Tenstan Tablets
- ▶ Tri-Pain
- ▶ Triaminicin Tablets
- ▶ Trigesic
- ▶ Trilisate Tablets and Liquid
- ▶ Uracel 5
- ▶ Ursinus Inlay Tabs
- ▶ Valesin
- ▶ Vanquish Caplets
- ▶ Vanquish
- ▶ Verin
- ▶ Viro-Med Tablets
- ▶ Wesprin Buffered
- ▶ Zorprin
- ▶ Zorprin Tablets

## NON STEROIDAL ANTIFLAMMATORY MEDICATIONS TO BE STOPPED PRIOR TO SURGERY

- ▶ Aches-N-Pain (Ibuprofen)
- ▶ Addaprin (Ibuprofen)
- ▶ Advil (Ibuprofen)
- ▶ Aleve (Naproxen Sodium)
- ▶ Anaprox DS (Naproxen Sodium)
- ▶ Anaprox (Naproxen Sodium)
- ▶ Ansaid (Flurbiprofen)
- ▶ Betazolidan (Phenylbutazone)
- ▶ Cataflam (Diclofenac Potassium)
- ▶ Clinoril (Sulindac)
- ▶ Coadvil (Ibuprofen)
- ▶ Daypro (Oxaprozin)
- ▶ Dolobid (Diflunisal)
- ▶ Dristan Sinus (Ibuprofen)
- ▶ Feldene (Piroxicam)
- ▶ Genpril (Ibuprofen)
- ▶ Haltran (Ibuprofen)
- ▶ IBU (Ibuprofen)
- ▶ IBU-Tab (Ibuprofen)
- ▶ Ibuprin (ibuprofen)
- ▶ Ibuprohm (Ibuprofen)
- ▶ Indocin (Indomethacin)
- ▶ Lodine (Etodolac)
- ▶ Medipren (Ibuprofen)
- ▶ Menadol (Ibuprofen)
- ▶ Midol 200 (Ibuprofen)
- ▶ Motrin IB (Ibuprofen)
- ▶ Motrin (Ibuprofen)
- ▶ Nalfon (Fenoprofen Calcium)
- ▶ Naprosyn (Naproxen)
- ▶ Nuprin (Ibuprofen)
- ▶ Orudis (Ketoprofen)
- ▶ Pamprin-IB (Ibuprofen)
- ▶ Pediaoprofen (Ibuprofen)
- ▶ Relafen (Nabumetone)
- ▶ Rufen (Ibuprofen)
- ▶ Saletto-200 (Ibuprofen)
- ▶ Tolectin
- ▶ Tolmetin Sodium
- ▶ Toradol (Ketorolactormethamine)
- ▶ Trendar (Ibuprofen)
- ▶ Trilisate (Choline Magnesium Trisalicylate)
- ▶ Ultraprin (Ibuprofen)
- ▶ Valprin (Ibuprofen)
- ▶ Voltaren (Diclofenac Sodium)

## PATIENT INFORMATION

Physician: (please circle one) CARRON / ZULIANI / MATHOG

Date:

Full Legal Name:

Nickname:

Sex: Age: D.O.B.: Race: Social Security #: - -

Address: City: State: Zip:

Would you like to receive promotional or informative correspondence via the US Postal Service? YES NO

Would you like to receive our monthly newsletter and other correspondence via Email? YES NO

Home Phone #: Cell Phone #: Email:

Employer: Occupation: Work Phone #:

Marital Status: (please circle one) Single (never been married) / Married / Divorced / Widowed / Partnered

Spouse's Name:

Have you or any family or friends been treated here before? YES NO

If YES, Name / Relationship / Doctor / Approx. Date:

Emergency Contact (not living with you):

Address: Phone#:

### If patient is a minor, please complete this section:

Father's Name: Phone#:

Mother's Name: Phone#:

Person responsible for bill (if other than patient):

Name: Relationship:

Address: City: State: Zip:

Employer: Phone #:

\*\* Do you have any allergies to medications? Please list allergies:

\*\* Do you have any food or environmental allergies? List allergens and reactions:

### REFERRAL SOURCE:

\*\*\*OUT OF STATE AND INTERNATIONAL PATIENTS, PLEASE LET US KNOW IF WE CAN ASSIST WITH YOUR TRAVEL PLANS\*\*\*

**Do you have or have you ever had:**

YES	NO		YES	NO	
_____	_____	Heart disease or heart trouble	_____	_____	Mitral valve prolapse
_____	_____	High blood pressure	_____	_____	Diabetes
_____	_____	Lung disease	_____	_____	Muscle weakness
_____	_____	Hay fever	_____	_____	Difficulty urinating
_____	_____	Kidney disease	_____	_____	Jaundice
_____	_____	Liver disease	_____	_____	Headache or dizzy spells
_____	_____	Epilepsy/seizures/neurological problems	_____	_____	Bowel/colon disease or problems
_____	_____	Thyroid or goiter problems	_____	_____	Shortness of breath
_____	_____	Chest pain	_____	_____	Back or neck trouble
_____	_____	Chronic cough	_____	_____	Ulcers/stomach trouble
_____	_____	Recent respiratory infection	_____	_____	Do you use eye drops?
_____	_____	Skin trouble/infections/rashes/irritations	_____	_____	Treatment of genital area
_____	_____	Keloid or ugly scars	_____	_____	Are you easily depressed
_____	_____	Glaucoma	_____	_____	Hiatal hernia
_____	_____	Phlebitis	_____	_____	Blood transfusion
_____	_____	Problems lying flat	_____	_____	Ankle swelling
_____	_____	Nosebleeds	_____	_____	Facial fractures
_____	_____	Fainting	_____	_____	Anemia
_____	_____	Asthma	_____	_____	Drug or alcohol dependency
_____	_____	Have you considered seeing a psychologist/ therapist			Height _____
_____	_____	Are you seeing a therapist now?			Weight _____
_____	_____	Are you on a special diet?			
_____	_____	Recent weight loss (amount)_____			
_____	_____	Any exposure to a communicable disease in the last 3 weeks? Explain			
		_____			
		_____			

**Please circle Y (Yes) or N (No):**

Do you take vitamins or herbal medications? .....	Y	N	Are you currently taking any drug or medications? How often? List (Include over the counter)
Do you drink alcohol? .....	Y	N	
Do you get cold sores or blisters? .....	Y	N	
Personal or family history of bleeding or clotting problems? .....	Y	N	
Have you taken cortisone or steroids in the past? .....	Y	N	
Have you ever taken Accutane? .....	Y	N	
Do you smoke? .....	Y	N	
Do you have a skincare regime? .....	Y	N	
Are you or could you be pregnant? .....	Y	N	
Are you a present carrier of a contagious disease? .....	Y	N	
Have you ever had local anesthesia? .....	Y	N	
Did you have a reaction to anesthesia? .....	Y	N	



**Previous Illnesses, Surgeries & Injuries:**

**Date:** \_\_\_\_\_ **Explain:** \_\_\_\_\_ **Physician:** \_\_\_\_\_

**Date:** \_\_\_\_\_ **Explain:** \_\_\_\_\_ **Physician:** \_\_\_\_\_

**Date:** \_\_\_\_\_ **Explain:** \_\_\_\_\_ **Physician:** \_\_\_\_\_

**Date of your last physical:** \_\_\_\_\_ **Date of most recent bloodwork:** \_\_\_\_\_

**Date of last EKG:** \_\_\_\_\_ **Have you ever had an abnormal EKG or Chest X-Ray?:** \_\_\_\_\_

**Family Physician:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_

**Specialty:** \_\_\_\_\_

**Family History:**

**Diabetes**       **Bleeding**       **Heart Disease**       **Anesthesia Problems**

**Other:** \_\_\_\_\_

**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_ (Patient or Guardian)

**INSURANCE INFORMATION**

**Do you have insurance coverage?:** \_\_\_\_\_

**Name of insurance company:** \_\_\_\_\_

**Name of Policy Holder:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**ID#:** \_\_\_\_\_ **Group#:** \_\_\_\_\_

**Address for claims:** \_\_\_\_\_

**Phone #:** \_\_\_\_\_

**(Please have your insurance card ready to present to the receptionist.)**

## AUTHORIZATION AND ASSIGNMENT OF BENEFITS (Please sign both)

I authorize to physicians furnish information to insurance carriers only concerning my illnesses and treatments.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

I assign to all payments for medical services rendered to me or my dependent. I understand that I am responsible for any amount not covered by assigned insurance.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

A photocopy of this authorization and assignment shall be considered as valid as the original.

It is customary to pay for professional services when rendered. Itemized receipts will be furnished on request. Patients are asked to file for routine office visits with their respective insurance companies. In the event of surgery, it is the patient's responsibility to furnish us with appropriate insurance forms on which to file surgery charges. The patient is responsible for all fees, regardless of insurance coverage.

## PHOTOGRAPHY CONSENT

I hereby give my permission to (physicians), or any assistant he may designate, to take photographs for diagnostic purposes, to enhance the medical report, during surgery, and postoperatively for evaluation purposes. I agree that these photographs will remain his property.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

I further authorize him to use such photographs for teaching purposes or to illustrate scientific papers, books, or lectures if, in his judgement, medical research, education, public education, or science will be benefited by their use. It is specifically understood that in any such publication or use, I shall not be identified by name.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_