Questionnaire

** indicates a required field*

Section A - Basic Information

*** Name of your colleague whose services you are reviewing (hereafter referred to as "Provider"):**

Provider has requested your review of their services, reputation in the field, professionalism and/or contributions as a clinician (hereafter, "Testimonial") for Provider's advertising and marketing purposes. Please complete Sections B and C below, as well as the Electronic Signatures Authorization.

*** Your Name**

First:

Last:

*** Relationship to Provider:**

- ☐ I am a current colleague of Provider
- ☐ I am a former colleague of Provider
- ☐ I volunteer with Provider in a professional capacity
- ☐ I attended school with Provider
- ☐ I have taught or mentored Provider
- ☐ Provider is one of my mentors or teachers
- ☐ I know Provider through a professional association

Section B - Testimonial

*** Please write your review of Provider below:**

Section C - Consent to Use/Disclosure of Name and Testimonial for Marketing Use

Provider seeks your consent to allow them to reproduce and distribute your Testimonial, along with your name, for use in advertisements, commercials, social media campaigns, medical and general interest publications, medical and patient education information and in all media (including but not limited to internet/online, TV, radio, newspapers and magazines) throughout the world (collectively, “Provider Marketing Uses”).

To ensure Provider is acting in accordance with your wishes and using your name and Testimonial with your consent, please read each consent below carefully before initialing.

*** Please note, Provider cannot use your name or Testimonial for Provider Marketing Uses unless you initial all of the following:**

I understand that my consent is voluntary and that I will not be entitled to any payment or renumeration as a result of any use of my name and/or Testimonial for Provider Marketing Uses. (Initial)

I understand that my consent is voluntary and that I will not be entitled to any payment or renumeration as a result of any use of my name and/or Testimonial for Provider Marketing Uses. (Initial)

If I decide to sign this form, I understand I have the right to revoke or withdraw my permission at any time to prohibit future use of my name and Testimonial. To do so, I must send written notice to Provider at Provider's physical address or to Provider's email address. (Initial)

I understand that Provider, as well as other persons or entities, will retain copies of any such electronic or printed versions and may retain these versions forever and that any revocation of this authorization will only extend to the versions of the information within Provider's control that have not been previously published. (Initial)

If not revoked/withdrawn by me, this authorization expires ten (10) years from the date that I sign it.

* **Electronic Signature:** ______________________________

I consent to sharing information provided here.

*** Today's Date:**

ELECTRONIC SIGNATURE AUTHORIZATION

By typing your signature on the line below, you authorize Provider to use your electronic signature for the Testimonial Release Form, including and without limitation to, all other consent documents, agreements, attachments and addendums (Collectively, "Documents"), connected in any way to the Testimonial

Release Form

Provider consents to accept your electronic signature as true, correct and binding and will post your Testimonial on Provider's website and in other public locations for marketing purposes in reliance on the validity of your electronic signature as represented by this signed authorization.

You agree that your electronic signature will be enforceable as and to the full extent of a handwritten signature as an original for enforcement/enforceability of the Testimonial Consent Form containing the electronic signature, whether in court (state or federal), arbitration, or otherwise. You will not raise any defenses or invoke regulatory or statutory claims attempting to invalidate the enforceability of the Documents to which the electronic signature is affixed.

WITHDRAWAL OF CONSENT

You have the right to withdraw your consent to the use of electronic signatures at any time. To withdraw your consent, you must inform Provider of your intent in writing.

To ensure Provider receives your withdrawal of consent, you shall either:

(a) send written notice to Provider at the email address you use to correspond with Provider; or
(b) mail your statement to Provider's business or home address.

ACKNOWLEDGEMENT

By adding my signature below, I authorize Provider to use my electronic signature in place of my handwritten signature for the Testimonial Consent Form and all other Documents.

* Name

First:

Last:

* **Signature:** ______________________________

I consent to sharing information provided here.

*** Today's Date:**