Indiana Society of Oral and Maxillofacial Surgeons
11307 Reflection Point Drive
Fishers, IN 46037
317.409.9330
isoms4489@gmail.com

AFFIDAVIT

I hereby certify that all offices in which I administer anesthesia services to my patients meet the same guidelines as those found in my primary office.

Primary office inspected on _____**,** 20____.

_____
Street Address, City, State, Zip Code

Other office locations where I administer anesthesia:

_____
Street Address, City, State, Zip Code

_____
Street Address, City, State, Zip Code

_____
Street Address, City, State, Zip Code

_____
Street Address, City, State, Zip Code

_____ _____
Printed Name Signature