Dental Practice approval to use facility

Your Practice name _____

Your full practice address: _____

_____

Your contact telephone number: _____ **Fax no:**_____

Your contact email address: _____

Who do we contact to confirm to book the facility _____

Do you wish to offer the room facility **Free of charge** **or** **Pay to use**
(delete as appropriate)

To whom would payment be made _____

Declaration:
I hereby accept and authorise The Dry Mouth Foundation to use our Dental practice environment for the purpose of treatment of Dry Mouth Treatment, undertaken and carried out by approved and licensed practitioners on behalf of the Foundation.

Printed name of person authorised on Behalf of the Practice _____

Usual Signature of authorised person _____

Date of authority _____**day**_____**month**_____**year**

Please return this document to:
The Dry Mouth Foundation. Monometer house. Rectory Grove, Leigh-on-Sea, Essex, SS9 2HN