The Society of Otorhinolaryngology and Head-Neck Nurses

PHOTO RELEASE FORM

I hereby grant permission to the Society of Otorhinolaryngology Head and Neck Nurses (SOHN), to use photographs and/or video of me tor my child taken on _____ at _____ in publications, and/or educational lectures/recordings related to the mission of the Society of Otorhinolaryngology Head and Neck Nurses.

First and Last Name: _____

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Phone (day): _____

Phone (evening) _____

Email Address _____

Date: _____

_____

(Signature of Adult, or Guardian of Minor Child)

Thank you!

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