



Facility Testimonial and Photo/Video Permission

Individual name and credentials: _____

Facility: _____

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My facility's name and/or logo for use by AORN solely in connection with my testimonial statement.

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To the extent my submission contains recognizable mentions or images of my employer health care facility, my facility has approved AORN's use as described above. All individuals who appear in any submitted photo and/or video appear willingly, understand, and have agreed to the above-described use and publication by AORN.

I either have the authority to sign and grant this permission on behalf of my facility or have secured an appropriate facility authorization below.

Individual: _____
Signature

On behalf of facility: _____
Facility Name

Date: _____