ZORGANICS INSTITUTE
BEAUTY AND WELLNESS

CLINIC FLOOR STUDENT SUPERVISION REQUIREMENT POLICY

Name _____

Program_ Instructor Program ▼ Start Date _____

Address_____

Email _____ Phone _____

By signing this acknowledgement receipt, you are stating that you have read and understand the student supervision requirement policy and you agree to follow all the rules and regulations provided within the classroom/clinic floor at Zorganics Institute.

Student Name_____Date _____

Signature _____ Date _____

Instructor Name_____ Date _____

Signature _____ Date _____

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