FREE TRIAL FORM

Name: _____

Date of Birth: _____
(Must be 18 +)

Address: _____

Phone Number: _____

What area of your body are you trying to lose inches from?

_____

I certify that I have read the contraindications page on the website (maloneydc.com) and I have no absolute contraindications and no relative contraindications that I will not first discuss with the doctor before trying my free trial of Ultimate Light. I also acknowledge that results vary and no specific results are guaranteed. If the doctor determines the therapy is not safe for you for any reason the therapy will not be performed and you will not be compensated in any way.

Signature: _____