TESTIMONIAL PERMISSION FORM

UOA
University Orthopaedic Associates
A DIVISION OF ORTHO ALLIANCE NJ

Dear University Orthopaedic Associates patient,

Thank you for sharing the positive experience you had at UOA.
Please clearly write your testimonial and check the appropriate boxes below.

TESTIMONIAL:

Print Name: _____

Please indicate which physician or therapist you saw: _____

Please indicate which location you were seen at or if you had a telemedicine visit:

☐ Somerset ☐ Princeton ☐ Wall ☐ Iselin ☐ Woodbridge ☐ Morganville ☐ Telemedicine Visit

APPROVALS/PERMISSION

May we use this testimonial on our website and/or marketing material? Yes ☐ No ☐

May we include your personal information with your testimonial in our marketing?
Check the appropriate box.

☐ You may use my full name
☐ You may use my first name
☐ You may use my initials
☐ Do not include my personal information

Signature: _____ **Date:** _____

Please email your completed patient testimonial form to StacyC@UOGNJ.com.