UVBioTek®
The Clear Choice in Skin Treatments™

SUGGESTED TREATMENT ROUTINE & SCHEDULE

Below is a standard time-based treatment routine. Because of our patented design the lamps are closer to you than in most other systems. This means that you will be receiving more light energy resulting in reduced treatment times. In a UVBiotek system, the typical maximum safe exposure is between 3 and 6 minutes.

Most patients take their treatments every other day. Most treatment times start at 10 seconds; increasing by 10 seconds for each succeeding treatment until patients either reaches their maximum safe exposure or clear**. DO NOT exceed 12 minutes per treatment unless directed by your doctor**.

As you know your specific treatment schedule and routine needs to be directed by your physician who should also determine the frequency of your treatments. Also, it is important that you see your physician at least every 4 months so that your condition can be properly assessed. This routine needs to be carefully followed to reduce the chances of burning and to insure that you will receive maximum benefits from your home UVB system:

The ideal treatment produces a pink color with no soreness and no tightness of the skin. The pink color should be gone within eight hours. Any burning, soreness, tightness, or excessive itching of the skin requires that you reduce the treatment time by 2 exposure levels and skip the next scheduled treatment.

If you experience the same results again at the same exposure time experienced in item above, then your Maximum Safe exposure is the immediate previous exposure time.

Reduce 1 additional exposure level for each treatment day missed.

21 or more consecutive days without any treatment – **START OVER!**

When skin is clear, maintain your maximum safe exposure level but reduce the treatment frequency as follows:

One treatment every 4 days for the next 16 days. Then 1 treatment per week unless directed otherwise by your Physician.

Patient: _____

Patient DOB: _____

Physician's Name: _____ **I agree with the above treatment schedule:** ☐

Make the following changes: _____

Physician's Signature: _____Date:_____

This Suggested Treatment Routine & Schedule must be submitted with the Patient Prescription