Designated Driver Form

Patient Name _____

Chart Number _____

Date _____

As the designated driver for: _____ I acknowledge that I must remain in the office during the entire time the patient is being treated. I understand that this is for the safety of the patient and no exceptions can be made. I understand that I will need to stay with the patient for several hours until they have recovered sufficently to care for themselves.

Driver's Name _____

Patient Full Name (Print) _____

Patient Signature _____

Witness Signature _____