CRATER LAKE
SURGERY CENTER, ASC

Driver Verification Form

I,_____ _____
Patient Name DOB

Certify that I have arranged for a driver over 18 years of age and/or transportation company to pick me up after today's procedure being performed at the Crater Lake Surgery Center.

Initial:_____

My Driver is: _____

Contact Phone Number:_____

Signature:_____ Date:_____

Witness/Employee:_____ Date:_____

833 Bennett Ave. Medford, Oregon . Phone: 541-200-3600 . Fax: 541-200-3601