OCCUPATIONAL TESTING CONSULTANTS

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Driver Rehabilitation Program

1. I understand that I have been referred by Dr._____ to Occupational Testing Consultants Driver Rehabilitation Program. I hereby consent for OTC records, regarding my driving evaluation and/or training to be released to Dr. _____. I also consent for the records regarding my driving evaluation to be sent to:
    a. _____
    b. _____
    c. _____
2. I have presented evidence to the Driver rehabilitation Program that I currently hold a valid Drivers License or I have permission from the Department of Motor Vehicles from the state which I am resident, to participate in the program.
3. I agree to hold OTC and its employees harmless for any claim(s) for injuries or damage arising out of my participation in the program.
4. I agree that OTC may release the results of this assessment, or any other data collected during my participation in the OTC driver rehabilitation Program to the Department of motor vehicle in the state that I am licensed or am a resident.

Patient Signature:_____ Date:_____

Witness Signature:_____ Date: _____