Company Name

CAREGIVER AFFIDAVIT

Date: _____ Time: _____

Patient: _____ ID#: _____

Attending Physician: _____

TYPE OF VISIT: ☐ Injectable medication administration. Type of medication: _____

Name of Caregiver(s): _____

Relationship to Patient: _____

REASON CAREGIVER UNABLE TO ADMINISTER INJECTABLE MEDICATION:

☐ Caregiver refused to be instructed. Explain: _____

_____

_____

☐ Busy work schedule. Explain: _____

_____

_____

☐ Functional limitations of caregiver. Explain: _____

_____

_____

☐ Other: _____

_____

_____

AFFIDAVIT

I, _____ , hereby swear or affirm that these statements are true and correct.

_____ _____

Signature of Caregiver Date

_____

Witness

_____

Home Care Representative