

DOPL Approved Chaperone Log

Licensee Name: _____ Case #: _____ Profession: _____

Date / Time	Patient ID or Initials	Patient Gender	Age	Procedure	Chaperone Signature	Signature in Patient's Chart
		<input type="checkbox"/> Male <input type="checkbox"/> Female				<input type="checkbox"/> Yes
		<input type="checkbox"/> Male <input type="checkbox"/> Female				<input type="checkbox"/> Yes
		<input type="checkbox"/> Male <input type="checkbox"/> Female				<input type="checkbox"/> Yes
		<input type="checkbox"/> Male <input type="checkbox"/> Female				<input type="checkbox"/> Yes
		<input type="checkbox"/> Male <input type="checkbox"/> Female				<input type="checkbox"/> Yes
		<input type="checkbox"/> Male <input type="checkbox"/> Female				<input type="checkbox"/> Yes
		<input type="checkbox"/> Male <input type="checkbox"/> Female				<input type="checkbox"/> Yes
		<input type="checkbox"/> Male <input type="checkbox"/> Female				<input type="checkbox"/> Yes
		<input type="checkbox"/> Male <input type="checkbox"/> Female				<input type="checkbox"/> Yes
		<input type="checkbox"/> Male <input type="checkbox"/> Female				<input type="checkbox"/> Yes
		<input type="checkbox"/> Male <input type="checkbox"/> Female				<input type="checkbox"/> Yes
		<input type="checkbox"/> Male <input type="checkbox"/> Female				<input type="checkbox"/> Yes
		<input type="checkbox"/> Male <input type="checkbox"/> Female				<input type="checkbox"/> Yes
		<input type="checkbox"/> Male <input type="checkbox"/> Female				<input type="checkbox"/> Yes

Note: For confidentiality purposes use Patient Record ID or Initials Only. AVOID USING PATIENT NAME.

This document may be submitted by uploading into Spectrum or by FAX to (801) 530-6404. **Include DOPL Case #** (found on stipulation) revised 02/10/2021