Verification of Physical Exam

I hereby acknowledge that the undersigned patient has had a physical wellness exam. This certifies that I have advised and encouraged the patient to follow up with of all recommended tests and procedures, but the patient is not obligated to follow these recommendations for the purpose of this document.

Health Care Provider Name (printed) Health Care Provider Signature

_________________________________ __________________________

License No. ________________________

Phone Number _____________________ Date _____________________

Employee or dependent: Upon obtaining your health care provider's signature, please sign and return this form to the district office.

Name (printed) Signature

_______________________ ______________________________

☐ I am an employee. ☐ I am a spouse. ☐ I am a dependent.