

Comprehensive Physical Examination Verification Form

I hereby confirm that\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

(Patient Name) Please Print

and was provided with the following examinations:

(Provider please sign/date on the line of the exam performed in your office.)

Provider Signature Printed Name Date of Exam

|  |  |  |  |
| --- | --- | --- | --- |
| Annual Physical |  |  |  |
| Annual Prostate Exam |  |  |  |
| Annual Pap/Pelvic Exam |  |  |  |
| Annual Mammogram |  |  |  |
| Colonoscopy Exam |  |  |  |
| Annual Dermatology Screening |  |  |  |
| Annual Vision Exam |  |  |  |
|  |  |  |  |

**Signature:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Signature of Employee or Spouse*

School District or College:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_