Medical Condition Verification Form

I hereby confirm that Carmen M Terry,
(Patient Name) Please Print

is being treated for a medical condition that requires routine visits, prescription maintenance, and/or regular testing and is in compliance with these standards of care.

(Provider please sign/date on the line of the exams performed or compliance for testing.)

	Provider Signature	Printed Name	Dates of Exam, Testing, etc
Medical Exam		John Smith, MD	8/15/15, 10/31/15 1/22/16, 3/8/16
Prescription Compliance		John Smith, MD	8/15/15 3/8/16
Labs		John Smith, MD	8/15/15 3/8/16
Testing (CT, X-ray, etc)			
Other exams Eye, foot, hearing, etc.			

Signature: Carmen M Terry
Signature of Employee or Spouse

School District or College: Test

School: _____