Chronic Medical Condition Verification Form

I hereby confirm that_____,

(Patient Name) Please Print

is being treated for a medical condition that requires either routine visits, prescription maintenance, and/or regular testing and is in compliance with these standards of care for **at least 6 months**.

Provider please sign and provide ALL dates to show compliance for at least 6 months. One date will not suffice for this form, there must be at least 6 months between dates.

	Provider Signature	Printed Name	Dates of Exams, Testing, etc
Medical Exam			
Prescription Compliance			
Labs			
Testing (CT, X-ray, etc)			
Other exams Eye, foot, hearing, etc.			

Patient Signature:_____

School or College:_____

Date of Birth: _____ Home Zip Code:_____

Return to Carmen Terry, Health and Wellness Coordinator at cterry@iu17.org, Fax to 570-567-1513 or Mail to PO Box 3609, Williamsport, PA 17701