Annual Physical Examination Verification

I hereby confirm that_____, presented at
(Patient Name) Please Print

my office on _____, 20___, and was provided with an annual physical
(Month) (Day)
Examination.

Signature:_____
Signature of Physician, Nurse Practitioner or Physician Assistant

Printed Name:_____

Date Signed:_____

Provider Address:_____

_____

Phone:_____

Patient Signature:_____
School or College:_____

Date of Birth:_____

Home Zip code:_____

Return to Carmen Terry, Health and Wellness Coordinator at cterry@iu17.org, Confidential Fax to 570-320-1348 or Mail to PO Box 3609, Williamsport, PA 17701