



## 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 examination.  
(Month) (Day)

**Signature:** \_\_\_\_\_  
*Signature of Physician, Nurse Practitioner or Physician Assistant*

**Printed Name:** \_\_\_\_\_

**Date Signed:** \_\_\_\_\_

Provider Address:  
\_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_

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

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

Date of Birth: \_\_\_\_\_

Home Zip code: \_\_\_\_\_

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