ANNUAL PHYSICAL OR UNDER PHYSICIAN CARE VERIFICATION FORM

\_\_\_\_\_\_\_\_\_ has had an annual checkup or is under ongoing physician care.

Employee or Spouse Name

\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Signature Date

ANNUAL PHYSICAL OR UNDER PHYSICIAN CARE VERIFICATION FORM

\_\_\_\_\_\_\_\_\_ has had an annual checkup or is under ongoing physician care.

Employee or Spouse Name

\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Signature Date