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

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

 Physician Signature Date