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: _____

Health Care Provider: _____

Address: _____

_____

_____

Phone _____

Signature: _____
Signature of City of Springfield Employee

**If physical examination provided by physician did not include phlebotomy services, it is highly encouraged to participate in the offered HRA which provide these services for FREE!*