NTIC
Northern Tier Insurance Consortium
Health & Wellness

# Annual Vision Examination Verification

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

my office on _____, 20____ and was provided with an annual preventative
(Month) (Day)

vision examination.

**Signature:** _____
*Signature of Optometrist*

**Printed Name:** _____

**Date Signed:** _____

Provider Address: _____

_____

Phone: _____

**Signature:** _____
*Signature of Employee or Spouse*

Participant Email: _____

School: _____