



## Mammogram Screening Verification

I hereby confirm that \_\_\_\_\_, presented at

(Patient Name) Please Print

my office on \_\_\_\_\_, 20\_\_\_\_ and was provided with a mammogram

(Month) (Day)

screening or ultrasound.

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

*Signature of Physician, Nurse Practitioner or Physician Assistant*

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

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

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

\_\_\_\_\_

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

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

*Signature of Employee or Spouse*

**Participant Email:** \_\_\_\_\_

**School:** \_\_\_\_\_