



## Health Screening Verification

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

(Patient Name) Please Print

my office on \_\_\_\_\_, 20\_\_\_\_ for their annual bloodwork.

(Month) (Day)

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