# Cervical Cancer Screening Verification

I hereby confirm that _____, presented at

(Patient Name) Please Print

my office on _____, 20____ and was provided with a cervical cancer

(Month) (Day)

screening.

**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:** _____