Annual Physical Form

Complete an annual physical exam with your primary care provider. This helps monitor your overall health, detect potential issues early, and create a personalized plan for maintaining well-being. Please use this Annual Physical Form as proof of visit with your provider.

Note to Health Care Provider: please do not provide any personal health information (PHI) on this form.

Employee Name: ______________________________________
(Please Print)

Employee No.: ____

Provider's Office/Name: _______________________________________

Date of Visit: ________________________
(Must be between 9/1/2024 - 8/31/2025)

This **Proof of Visit** confirms that the patient above received the following preventative care:

SCREENING TYPE

This **Proof of Visit** confirms that the patient above received an Annual Physical within the dates of ***9/1/2024 - 8/31/2025.***

PROVIDER INFORMATION

I certify that the patient listed above received the exam(s) indicated on this form.

Provider Signature: ___________________________ **Date:** __________