Preventive Care Form

Please use the preventive care form to show your proof of visit to any of the below preventive screening options. Complete the screening that is most appropriate for you - whether based on age or recommended by your doctor.

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

- ❑ **Well-Woman Exam**
- ❑ **Mammogram**
- ❑ **Colonoscopy**
- ❑ **Dental Exam/Cleaning**
- ❑ **Skin Check**
- ❑ **Vision (Eye) Exam**
- ❑ **Prostate Exam**

PROVIDER INFORMATION

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

Provider Signature: _____ **Date:** _____

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TAKE THE NEXT STEP