



Proof of Visit Form

Patient's Name: _____
(Please Print)

Physician Office/Name: _____ Date of Visit: _____

This Proof of Visit confirms that the patient named above received the following preventative care
(Please check the exams that apply):

Annual Preventative Exam

Biometric Screening

PHYSICIAN:

Yes No I certify that the patient listed above received the exams indicated on this
form on:

Month: _____ Day: _____ Year: _____

Physician Signature: _____ Date Signed: _____

For Office Use Only:

I authorize that the Proof of Visit and/or Biometrics were viewed and approved:

HR Staff Member Signature: _____ Date: _____

**Please submit your completed form to Human Resources by May 31st, 2022 in order to
receive credit. For questions call 937.393.3431 ext. 2560**