SOUTHERN STATE COMMUNITY COLLEGE

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, 2019 in order to receive credit. For questions call 937.393.3431 ext. 2560