PHYSICIAN VERIFICATION FORM
FOR 2017 ACU WELLNESS PREMIUM DISCOUNT

SECTION I: ***TO BE COMPLETED BY ACU EMPLOYEE*** **(PLEASE PRINT)**

Name: _____

Banner ID: _____

I certify that the information below is accurate to my knowledge and that if I knowingly falsify any documents relating to the wellness program, I will be disqualified from the discount program. I understand it is solely my responsibility to follow up with my personal physician for results outside of the normal range or if I have any questions or concerns regarding my health.

Signature: _____ Date: _____

SECTION II: ***TO BE COMPLETED BY YOUR PHYSICIAN.***

Date of Physical Examination: (Has to be between 10/01/2015 and 9/30/2016 to qualify)

_____

I certify that I have worked with the patient listed above to provide the following care:

☐ Age appropriate preventive exam (i.e. pap smear, mammogram, prostate exam, etc)

☐ Annual physical

☐ Completed a tobacco cessation program

Physician's Signature: _____

Physician's Name (please print): _____

Physician's Address: _____

This form should be returned to Elsa Dunson at EDunson@holmesmurphy.com or fax to 214.346.6797.