

PHYSICIAN VERIFICATION FORM



APG offers a weekly insurance discount to employees when each adult member visits their doctor for their annual preventative visit and participates in regular wellness activities. To verify the annual visit, each field on this form must be filled out accurately and legibly.

Submit the completed form to the HR Team. Forms can be dropped off at the Clearwater or Lakeland office.

Do not submit any personal medical information or documents with this form.

SECTION 1 - TO BE COMPLETED BY PATIENT

Patient's First Name	MI	Patient's Last Name
<input type="text"/>	<input type="text"/>	<input type="text"/>
Patient's Date of Birth (MM/DD/YYYY)	You are: (Check 1)	
<input type="text"/>	Employee <input type="checkbox"/>	Spouse <input type="checkbox"/>
		Child (18+) <input type="checkbox"/>
Patient's Signature: X _____	Date: <input type="text"/>	<input type="text"/>
	(Month)	(Day)
		<input type="text"/>
		(Year)

SECTION 2 - TO BE COMPLETED BY PHYSICIAN / PROVIDER

LICENSED MEDICAL PROFESSIONAL SIGN-OFF

I verify that the patient above completed a wellness visit at my office on Date: _____

Phone Number of Facility: _____

Physician/Provider Name: _____

Signature: _____