ANNUAL PREVENTIVE PHYSICAL VERIFICATION

I verify that _____ obtained an
(employee name)

Annual physical on _____ from _____
(exam date) (Physician or Practice Name)

To Be Completed by Physician/Medical Practice:

Please include address stamp, if available

Physician Name (print): _____

Physician Signature: _____

License Number: _____

Phone Number: _____

Date: _____

To Be Completed by Employee:

Non-Locke Lord Medical Plan Participation:

_____
Medical Insurance Company

Employee Name (Print): _____

Employee Signature: _____

*For this verification form, a routine physical exam includes:

- Taking of a family medical history, height, weight, and blood pressure
- Checking the eyes, ears, nose, throat, abdominal area, swallowing, appetite, digestion, circulation, and lungs
- Doing a full blood panel
- Additional screenings/tests such as requested by your physician.

Please submit your completed form to the Benefits Team at HRHotline@lockelord.com