ANNUAL WELL CARE VISIT ATTESTATION FORM

DICKENSON COUNTY PUBLIC SCHOOLS

PO Box 1127, Clintwood, VA 24228 Phone: (276) 926-4643 ▪ FAX: (276) 926-6374

Take this form with you to your scheduled doctor's visit to be completed and signed by the care provider. It is the participant's responsibility to submit this form to Human Resources as outlined below.

Patient Information

Patient's Full Name: _____ Date of Birth: _____

Policy Holder: _____ E-mail: _____

Physician Information

Physician Office/Name: _____

Office Phone/Address: _____

Date of Visit: _____

- This Proof of Annual Well Care Visit form confirms that the patient above received an annual well care visit between **January 1, 2018 and December 31, 2018.**

Physician Signature

I certify that the patient listed above received the exam indicated on this form:

Physician Signature: _____ Date: _____

Note that this form is to confirm that the above noted patient has received their annual well care visit exam only.

Patient Signature

I authorize the release of my Proof of Annual Well Care Visit to Dickenson County Public Schools. I understand that the Dickenson County Public School will be notified that I received the exam indicated on this form and that no test results are to be shared with Dickenson County Public Schools

Patient Signature: _____ Date: _____

Please submit the completed form to Reba McCowan @ rmccowan@dcps.k12.va.us or fax to (276) 926-6374 by January 31, 2019 to receive credit for the 2018-2019 Dickenson County School Board Insurance Incentive Program.