BAILEY
NURSERIES

EMPLOYEE ANNUAL PHYSICAL EXAMINATION
and
HEALTHCARE PROVIDER CERTIFICATION

Read instructions carefully. You and your healthcare provider must complete this form. Completion of this form is required for proof of your annual physical examination. Return completed form along with all other certifications to Human Resources.

A) To be completed by the Employee

Last Name	First Name	Middle Initial

XXX-XX - ___ ___ ___ ___

Last 4 digits of Social Security Number

I certify that I completed an annual physical examination with my physician.

Signed: _____

Employee Date

B) To be completed by the Healthcare Provider

CERTIFICATION

The above-named employee received a physical examination on the date(s) indicated below.

Licensed Physician (Print)	
Date of Exam	License Number
Physician Signature	Date

HEALTHCARE PROVIDER: PLEASE GIVE THIS FORM BACK TO THE PATIENT/EMPLOYEE