

**EXAMEN FÍSICO ANUAL DEL EMPLEADO
y
CERTIFICACIÓN DEL PROVEEDOR DE SALUD**

Lea las instrucciones atentamente. Usted y su proveedor de atención médica deben completar este formulario. Se requiere completar este formulario para la prueba de su examen físico anual. Devuelva el formulario completo junto con todas las demás certificaciones a Recursos Humanos.

A) Completado por el Empleado

| | | |
|----------|---------------|---------|
| | | |
| Apellido | Primer Nombre | Inicial |

XXX-XX - ____ ____ ____ ____

Los ultimo 4 numeros del Seguro Social

Certifico que completé un examen físico anual con mi médico.

Firmado:

Empleado

Fecha

B) Para ser completado por el Proveedor de atención médica

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

**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