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# ANNUAL WELL VISIT
# PHYSICIAN AFFIDAVIT

**Employee / Spouse Information (Please Print):**

| Last Name: | First Name: | Middle Initial: |
|---|---|---|
| Choose One: ☐ Employee ☐ Spouse | Employee ID: | Employee Department / Store Location: |

**Provider Information (Please Print):**

| Physician Name: | | |
|---|---|---|
| Facility Name: | | |
| Street Address: | | |
| City: | State: | Zip Code: |

**Provider Certification:**

I am certifying that the patient listed above obtained an examination on _____ / _____ / 2015 that met the minimum screening requirements for their age.

Physician's Signature _____ Date _____

**Acknowledgment and Agreement:**

I understand that to be eligible for this preventive screening incentive, I must acquire a physical exam by a licensed physician in 2015. I further understand that my signature below certifies that I have complied with the requirement of completing the physical examination.

Employee / Spouse Signature _____ Date _____

**Fax this completed form to Corporate Human Resources at (480) 951-8619 OR (480) 609-0995, or email to benefits@discounttire.com by December 31, 2015**