



*Employees and Spouses Qualify for a \$50 Gift Card!*

## 2019 PHYSICIAN AFFIDAVIT of ANNUAL WELL VISIT

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

Last Name:		First Name:		Middle Initial:
Choose One: <input type="checkbox"/> Employee <input type="checkbox"/> Spouse		Employee ID:	Employee Department / Store Location:	
Personal Email Address:		Employee Address:		
City:		State:	Zip Code:	

### 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 \_\_\_\_ / \_\_\_\_ / 2019 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 2019. I further understand that my signature below certifies that I have complied with the requirement of completing the physical examination. ***\*\*Annual Preventive Care Visits include certain routine lab tests. These routine lab tests are paid when billed by your provider with a wellness diagnosis. Please call the number on the back of your ID card for additional information on preventive labs covered\*\****

\_\_\_\_\_  
Employee / Spouse Signature

\_\_\_\_\_  
Date

**Email this completed form to Corporate Human Resources at [benefits@discounttire.com](mailto:benefits@discounttire.com) by December 31, 2019.**