HEALTH RISK ASSESSMENT

Employee Name: ______________________________ Employee ID# E____________

Patient Name: ______________________________

I certify that on this date __________/__________/__________ I performed a routine physical health maintenance examination for the patient named above.

____
Physician's Signature

____
Date

____
Physician's Name (Please print)

____
Address

____
City, State, Zip

____
Phone Number

PLEASE FAX FORM TO 1-248-282-8691 *-OR-* SCAN AND EMAIL YOUR FORM DIRECTLY TO sdare@bloomfield.org *-OR-* DROP OFF IN BASKET LOCATED IN H.R. OFFICE NO LATER THAN SEPTEMBER 15 – FORMS WILL NOT BE ACCEPTED AFTER THIS DATE