Calcasieu Parish School Board

BUILDING FOUNDATIONS FOR THE FUTURE

Dr. Jason VanMetre, Superintendent

VERIFICATION OF SERVICES FORM

One form per date of service

SECTION 1: PATIENT INFORMATION (*PATIENT*- Please print)

First Name | Middle Initial | Last Name

Street Address | City | State | Zip Code

( ) - Age: ☐ ☐ Date of Birth:

Primary Phone Number | Male | Female | Month | Day | Year

Patient Disclosure Statement: I understand that verification data will be submitted to CPSB's Wellness Program in the Risk Management Department for incentive purposes. All information will remain confidential and will be protected as required by law under the Health Insurance Portability and Accountability Act (HIPAA). I am voluntarily participating in CPSB's Wellness Program.

_____ _____

Patient Signature | Date

To receive credit, services must be completed between May 1, 2025, and April 30, 2026.

SECTION 2: SERVICES RENDERED

Verification of Services

The patient named above was seen in my office on _____ for the following service(s) (please check:)

☐	Flu shot/vaccine	☐	Annual Blood Work	☐	Prostate Exam
☐	Shingles or Covid shot/vaccine	☐	Wellness / Physical Exam	☐	Colonoscopy
☐	Pneumonia shot/vaccine	☐	Mammogram	☐	Eye Exam / Dental Exam (circle one)

SECTION 3: PHYSICIAN INFORMATION

Provider's Name _____ Phone Number:(___)____-_____

(Please Print) First Last

_____

Street Address | City | State | Zip Code

PHYSICIAN'S SIGNATURE (req'd) | DATE