**Moline-Coal Valley School District No.40**
**Wellness Physical Exam Form**

**(USE BLACK INK ONLY)**

Employee/Policy Holder Name: _____

Patient: _____ Relationship: _____

The patient indicated above has completed a wellness physical on _____
(date)

Physician's Name: _____

Physician's Address: _____

_____

_____
Physician's Signature

***EMPLOYEE, The top portion of this form must be completed by your physician : OR, you must attach a copy of the Explanation of Benefits (EOB) for this physical. To access your EOB, register your account at www.umr.com Physicals must be completed by your regular physician, not a walk in clinic.***

**Physicals must be completed between January 1 – December 1 on an annual basis and turned in no later than December 1st.**

**Please return either this completed form or your EOB to the Insurance Office at MEC 1900 52nd Ave., Moline, IL 61265; fax 309-743-8143 or via email sbartels@molineschools.org**