Penn Medicine
Lancaster General Health

Annual Physical Exam OR Preventive Care Form

Employee completes the following information: (Please Print to ensure accuracy.)

NAME: _____ _____ _____
(Last) (First) (MI)

BIRTH DATE: _____ GENDER: Female Male

ADDRESS: _____

PHONE: _____ EMAIL: _____

I understand that preventive services, as described by the preventive schedule, are available at no out of pocket cost. However, if something is diagnosed or additional tests are performed, I may have out of pocket costs. I also understand that any fees incurred by my medical provider for form completion will not be reimbursed by my employer.

SIGNATURE: _____ DATE: _____

Physician completes the following information:

I declare I have provided an annual physical examination for this individual on the following date:

_____.
OR
I declare that this individual is up to date on their preventive care recommendations as of the following date:_____.

Physician's Signature: _____ DATE: _____

Print Name: _____

Please return this form
By November 30, 2025 to:
Jenn Reed, jenn.reed@nextphasewellness.net or Whitney Stauffer