COLLIER COUNTY PUBLIC SCHOOLS

Preventive Screening Verification Form

Attention: Pathways Coach,

Patient name: ____________________________________

Date of Birth: _______________

The above patient was seen for the procedure marked below.

☐ Annual Physical Exam   Date of service: ______________

☐ Mammogram   Date of service: ______________

☐ Colonoscopy   Date of service: ______________

Thank you,

____
(Physician Printed Name)

____
(Physician Signature)

(Place office stamp here)

*** *PROVIDER INFORMATION (STAMP, OFFICE AND LOCATION, ETC.)* ***

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