

PHYSICIAN SCREENING FORM(PCP Form)

Take this form with you to your scheduled annual physical exam to be completed and signed by your primary care physician. It is the participant's responsibility to submit the Physician Screening Form as part of the Oakland County's OakFit wellness program.

Employee Contact Information

Company Name: Oakland County

First Name: _____ Last Name: _____

Date of Birth: _____ Employee ID# _____

Department: _____

Phone: _____ Email: _____

I understand that my individual health information will not be shared with Oakland County. I acknowledge that I have been provided access to the Privacy Practice Policy, which can be found at oakgov.com/wellness.

Patient's Signature: _____ Date: _____

Physician completes this section:

This Physician Screening Form confirms that the patient named above received the following preventative care between January 1 and December 31.

I certify that the patient listed above received an annual preventative exam (physical performed by primary care physician) on: _____

Physician Name: _____

Physician Signature: _____ UPIN/NPI# _____

Office Phone: _____



Please return completed form to
OakFit wellness by December 31.

Questions?
Call: 248-858-5473 or
Email: oakfit@oakgov.com