AMERICA'S TIRE | DISCOUNT TIRE | DISCOUNT TIRE DIRECT

Qualify for a $50 Gift Card!

ANNUAL WELL VISIT
PHYSICIAN AFFIDAVIT

Employee / Spouse Information (Please Print):

Last Name:	First Name:	Middle Initial:
Choose One: ☐ Employee ☐ Spouse	Employee ID:	Employee Department / Store Location:

Provider Information (Please Print):

Physician Name:		
Facility Name:		
Street Address:		
City:	State:	Zip Code:

Provider Certification:

I am certifying that the patient listed above obtained an examination on _____ / _____ / 2016 that met the minimum screening requirements for their age.

Physician's Signature _____ Date _____

Acknowledgment and Agreement:

I understand that to be eligible for this preventive screening incentive, I must acquire a physical exam by a licensed physician in 2016. I further understand that my signature below certifies that I have complied with the requirement of completing the physical examination.

Employee / Spouse Signature _____ Date _____

Fax this completed form to Corporate Human Resources at (480) 951-8619 OR (480) 609-0995, or email to benefits@discounttire.com by December 31, 2016