NTIC
Northern Tier Insurance Consortium
Health & Wellness

Annual Vision Examination Verification

I hereby confirm that _____, presented at
(Patient Name) Please Print

my office on _____, 20____ and was provided with an annual preventative
(Month) (Day)

vision examination.

Signature: _____
Signature of Optometrist

Printed Name: _____

Date Signed: _____

Provider Address: _____

_____

Phone: _____

Signature: _____
Signature of Employee or Spouse

School: _____