



## 2019-2020 Proof of Primary Care Provider/ Primary Care Provider Declaration

I have a Primary Care Provider/have declared a Primary Care Provider.

**Physician's Name:** \_\_\_\_\_

**Physician's Full Address:** \_\_\_\_\_

\_\_\_\_\_

**Physician's Phone Number:** \_\_\_\_\_

**Signature of Employee or Spouse:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**School:** \_\_\_\_\_