



Annual **Vision Exam** Verification Form

This form verifies that the following FSD145 employee has completed an annual Vision examination.

The vision history and examination details will remain on file at the physician's office.

Please submit only this form to the FSD145 Business office at health@fsd145.org.

Employee Name: _____

Date examination was completed: _____

Printed physician name _____

Physician signature _____ Date _____