Bloomfield Hills Schools

HEALTH RISK ASSESSMENT

Employee Name: _____ Employee ID# E_____

Patient Name: _____

I certify that on this date _____/_____/_____ I performed a routine physical health maintenance examination for the patient named above.

_____ _____
Physician's Signature Date

_____
Physician's Name (Please print)

_____
Address

_____
City, State, Zip

_____
Phone Number

***Please Note**: We are fully transitioning to this new form in 2019. We will continue to honor the previous form until 09/17/2018.*