



Wheaton Franciscan Healthcare

Physical Examination Documentation Form

Name of Patient: _____

Date of Physical: _____

I verify that this patient was seen within the past 12 months & is free of communicable diseases.

Physician's Signature

Date Signed

Physician's Printed Name

Name of facility

(Please send or fax form to Milwaukee or Racine at the numbers listed below. Thank you!)

For Milwaukee:

Lea Toney

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For Milwaukee Therapy Requests:

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For Racine:

Marcia L. Garcia

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