Dear Physician,

In an effort to improve awareness of the importance of preventive health practices, Marquette University is asking their employees to verify their annual exam and preventive screening status to qualify for a discount on their medical insurance premium. Your patient is an employee of Marquette University and requires your assistance to verify that they have had an annual physical exam and that they are up-to-date on the listed cancer screening tests, or that these tests are not warranted at this time. Please verify the status of these tests by completing the attached form and returning it via mail or fax to the phone/address listed on the bottom.

Thank you in advance for your cooperation with this health promotion effort of Marquette University. If you have any questions please feel free to contact the Aurora Total Health Department at 877-765-3213, Option #1.
**SECTION I: TO BE COMPLETED BY MARQUETTE UNIVERSITY EMPLOYEE (Please Print)**

Date: ___________  Company Name: Marquette University

First Name: ___________________  Last Name: ___________________  Date of Birth: _______________

Address: ____________________________________________  City: __________________  State: _____  Zip: _______

Home Phone: (________)_______________________  Work Phone: (________)_______________________

Sex:  □ Male  □ Female  Employee (ID# ____________________________)

☐ YES, I would like to participate in the voluntary 2012/13 Preventive Care program. (Section II must be completed.)

☐ NO, I do not wish to participate in the voluntary 2012/13 Preventive Care program. I understand that I will not be eligible for a preventive care discount on my 2014 medical premiums.

Signature: ____________________________________________________________________________________

**SECTION II: TO BE COMPLETED BY PHYSICIAN (Please check one box for the physical exam and one box for each test.)**

**Annual Physical Exam (Men and Women)**
My patient is (check one):  □ Up-to-date. Date of last physical exam: __/__/____
☐ Not Applicable. Note reason: __________________________________________________________________
☐ Not up-to-date

**Cervical Cancer Screening - Pap Test (Women)**
My patient is (check one):  □ Up-to-date. Date of last pap test: __/__/____
☐ Not Applicable. Note reason: __________________________________________________________________
☐ Not up-to-date

**Breast Cancer Screening – Mammogram (Women)**
My patient is (check one):  □ Up-to-date. Date of last mammogram: __/__/____
☐ Not Applicable. Note reason: __________________________________________________________________
☐ Not up-to-date

**Colorectal Cancer Screening – Colonoscopy or Screening Test (Men and Women)**
My patient is (check one):  □ Up-to-date. Date of last colorectal screening: __/__/____
Type of Colorectal Cancer screening test: __________________________________________________________________
☐ Not Applicable. Note reason: __________________________________________________________________
☐ Not up-to-date

Physician’s Signature: ____________________________________________________________________________

Physician’s Name (Please Print): __________________________________________________________________

Physician’s Address: ____________________________________________________________________________

Physician’s Phone Number: _______________________________________________________________________

Please email/fax/mail this form no later than October 31, 2013 to:

Email: joan.stigler@aurora.org  Fax: (414) 525-2570
Mail: Aurora Health Care Total Health Department / 11217 W. Forest Home Avenue, 1E, Franklin, WI 53132