

Human Resource Training

MEDICAL / DENTAL EXAMINATION REPORT

Name of Client: _____ Date: _____

Purpose of Visit: _____ Routine Exam _____ Follow-Up Appointment
 _____ Other (Please Explain):

Diagnosis / Problem Noted:

Special Instructions:

Name of Physician / Dentist:

Phone: (_____) _____ - _____

Signature of HRT Provider

Date