McLaren Internal Medicine Faculty and Residency Group Practice 3230 Beecher Rd., Suite 2 Flint, MI 48532

I have reviewed with the resident

(Patient Name) \_\_\_\_

medical history, physical examination, diagnosis, and results of test and treatments and agree with the patient's care as documented above.

Date: \_\_\_\_\_ Time: \_\_\_\_\_

Physician Signature: \_\_\_\_\_



Patient Name:

Date of Birth: