

WELLNESS BONUS PROOF OF PARTICIPATION FORM

ANNUAL/SEMI ANNUAL DENTAL EXAMINATION WITH CLEANING

USE OF THIS FORM IS MANDATORY: NO SUBSTITUTIONS WILL BE ACCEPTED

Dear Doctor or Health Care Provider:

My employer is sponsoring a wellness program to help me make positive changes (or maintain my good health) in several areas. I have voluntarily enrolled in this program. I have to provide verification that I executed an Annual/Semi Annual Dental Examination and cleaning my Dentist. Part of the examination needs to include a discussion with the my oral hygiene and its correlation to overall health. By signing this form you acknowledge that you completed an annual/semi-annual dental examination and cleaning with the employee and discussed their oral health with the employee.

Please mail or fax the completed form to GISC as stated below. Thank you.

PATIENT'S NAME: _____

DATE OF THE EXAM: _____

EMPLOYER'S NAME: CITY OF BURLINGTON

Physician/Health Provider Signature

Date

Phone number

City

State

Zip

**RETURN COMPLETED FORM TO: Attention Wellness Department
GISC, P.O. Box 9120, Marshfield, MA 02050 FAX: 781-829-8770**