

WELLNESS BONUS PROOF OF PARTICIPATION FORM

ANNUAL PHYSICAL EXAMINATION WITH PRIMARY CARE PHYSICIAN**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 Physical Examination with my Primary Care Physician. Part of the examination needs to include a discussion with the my Primary Care Physician about my personal data/numbers/results regarding cholesterol, weight and waist size, blood pressure, and sugar values. By signing this form you acknowledge that you completed an annual physical examination with the employee and discussed these items and values 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

TOTAL CHOLESTEROL: (12-hour fast) _____ HDL: _____ LDL: _____

GLUCOSE: (12-hour fast) _____

BLOOD PRESSURE: _____

WEIGHT: _____

HEIGHT: _____

BODY MASS INDEX: _____

WAIST SIZE: _____

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**