

# TOWN OF MOREHEAD CITY WELLNESS PROGRAM VERIFICATION FORM



\_\_\_\_\_ was seen in our office on \_\_\_\_\_  
(Please print name) (Date MM/DD/YYYY)

*for his/her (circle one):\*\**

- Annual physical
- Gynecological exam
- Dental exam
- Eye exam
- Dermatologist exam
- Chiropractor visit
- Mammogram
- Colorectal screening
- Blood donation
- Gender or age specific tests or exams
- Supervised weight loss program
- Immunizations (preventative)
- Nutritional counseling
- Other service(s) \_\_\_\_\_

\_\_\_\_\_  
(Please specify)

*\*\*Attach physician receipt, Explanation of Benefits (EOB), or other documentation as necessary. All information contained on this page and other attachments will be kept completely confidential and filed in a secure location separate from wellness file and employee's personnel file.*

\_\_\_\_\_  
Physician or Designee/Agency (please print)

\_\_\_\_\_  
Physician or Designee/Agency (signature)

\_\_\_\_\_  
Date

For MHC Human Resources Department use only:

Date Received \_\_\_\_\_ Approved \_\_\_\_ Yes \_\_\_\_ No Initials \_\_\_\_\_