2023 WELLNESS INCENTIVE ACKNOWLEDGMENT FORM

EMPLOYEE NAME: _____ DATE: _____

By signing, I acknowledge I received a Preventive Care service as recommended by age by my physician on _____.
I understand I must return this form to Human Resources for this physician visit in order to qualify for any workplace incentives.

_____

EMPLOYEE SIGNATURE

FOR PHYSICIAN USE ONLY

PHYSICIAN NAME: _____

DATE OF VISIT: _____

_____

PHYSICIAN SIGNATURE