



WELLNESS DOCUMENTATION FORM



Employee Name *(please print)*: _____

Primary Branch: _____

Type of Visit:

- Preventative Health Visit
- Immunization
- Dental Teeth Cleaning
- Financial Advisor Meeting
- Vision Screening
- Blood Donation

Date of Visit: _____

Provider Name: _____

Practice Name: _____

Address: _____

Optional Description:

(Please include any other information that you feel may be beneficial in approving your wellness documentation. Examples may include a high-level overview of the type of preventative visit or immunization – e.g. dermatology appointment, Tdap immunization, etc.)

I acknowledge that the employee above attended the indicated visit on the documented date.

Provider Signature: _____

I certify that the above mentioned is accurate to the best of my knowledge.

Employee Signature: _____