4 South Eagleville Road
Mansfield, CT 06268

Be Well
An EHHD Wellness Program

EHHD
Eastern Highlands Health District

Tolland Employee Rewards Program
Medical Verification Form

Please print clearly... we can't *use* the information if we can't *read* the information!

Employee fills out this section

Date of exam: _____

Employee's (or Spouse's) Name: _____

Health Care Provider's Name: _____

Health Care Provider's Specialty: _____

Health Care Provider's Address: _____

_____

Health Care Provider fills out this section

Instructions for Health Care Provider:

Please place your *initials* next to each statement that applies to this visit.

I certify that the above named person (an employee/spouse of the Town of Tolland):

_____ Received a physical exam (or annual gynecological exam) on the date indicated above.

_____ Had their Body Mass Index assessed on the date indicated above

_____ Had their blood pressure checked on the date indicated above

_____ Had their blood cholesterol levels checked on the date indicated above

_____ Had their blood glucose levels checked on the date indicated above

Comments:

_____ _____

Health Care Provider Signature **Date**

Employee or Health Care Provider:

FAX: 860-429-3321 **Email:** be_well@ehhd.org **Mail**:4 S. Eagleville Rd, Mansfield, CT 06268