Annual Blood Draw Verification Form

To be completed by 6/30/2024

Employer: **City of Cheyenne**

Employee Name: _____

Provider Verification:

This form is to verify compliance with a wellness program through the patient's employer. In an effort to encourage all employees to receive an annual blood draw, we are using the verification form to manage participation. The blood draw will include A1C, Glucose, and Cholesterol measurements. As part of the patient's wellness program, this form will need to be completed and returned to the City of Cheyenne Human Resources Office.

I, _____ (Provider Name), conducted a blood draw for the patient listed above including A1C, Glucose, and Cholesterol measurements.

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____

Provider Address: _____ Phone: _____

(please print or stamp)