Annual Wellness Exam Verification Form

To be completed by 6/30/2024

Employer: **City of Cheyenne**

Employee Name: _____

Physician Verification:

This form is to verify compliance with a wellness program through the patient's employer. In an effort to encourage all employees to visit a Primary Care Physician, we are using the verification form to manage participation. The wellness visit will include height, weight, and blood pressure 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, _____ (Physician Name), conducted a wellness visit for the patient listed above including height, weight, and blood pressure measurements.

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____

Physician Address: _____ Phone: _____

(please print or stamp)