



CITY OF FORT LAUDERDALE – BENEFITS SECTION

WELLNESS INCENTIVE PROGRAM PHYSICIAN VERIFICATION FORM

ELIGIBLE EMPLOYEES ENROLLED IN A CITY MEDICAL PLAN AS A DEPENDENT (SPOUSE/DP) OF ANOTHER CITY EMPLOYEE

Rev: 1 | Date: 01/15/2019 | Print Date: 04/18/2018

This form is for use by Eligible Employees participating in the City’s Wellness Incentive Program (WIP) who are enrolled in one of the City’s Medical Plans as a dependent (spouse/domestic partner (DP)) of another City Employee.

Instructions:

1. Please complete the top portion (PART 1).
2. Have your physician/practitioner complete the wellness program activity verification section (PART 2) to certify that the service(s) indicated below have been completed.
3. Submit this completed form along with your completed Wellness Incentive Program Tracker form (PART 3) to the City’s onsite Wellness Coordinator, Kerri Holden, by December 31 to receive your WIP payout in accordance with the WIP’s eligibility rules and conditions. **Both Forms must be completed and received by December 31.**

PART 1. To be completed by Employee:

ELIGIBLE EMPLOYEE NAME COVERED AS SPOUSE/DP (PRINT)	EMPLOYEE ID #	DATE OF HIRE/PROMOTION
EMPLOYEE NAME THAT HAS PRIMARY MEDICAL COVERAGE (PRINT)	EMPLOYEE ID #	

PART 2. Wellness Program Activity verification to be completed by Physician/Practitioner:

I hereby confirm that the above reference employee (please check all completed services):

CHECK ALL COMPLETED SERVICES	PROGRAM ACTIVITY COMPLETED	DATE COMPLETED
	Completed an Annual Physical (Preventive Exam)	
	Completed a Biometric Health Screening that included: <ul style="list-style-type: none"> • a blood pressure check, • cholesterol screening, • a blood glucose/blood sugar screening, • and a measurement of height and weight. 	
	Got a Flu Shot	
	Completed a Mammogram	
	Completed a Prostate-specific antigen (PSA) screening	
	Completed a colon cancer screening (colonoscopy)	
	Completed an OB/GYN Exam	
	Completed a Cervical cancer screening	

Please affix the provider’s official stamp on this completed document prior to submission.

Print Name of Health Screener

Signature of Health Screener

Telephone Number

Date

Part 3. Submit Forms:

Please fax this completed form along with your completed Wellness Incentive Program Tracker form to

Fax: 860-847-5126

OR submit/mail to:

City of Fort Lauderdale Health and Wellness Center

4750 N. Federal Highway, Suite 300

Fort Lauderdale, FL 33308

Attention: Kerri Holden

Phone: 954-652-1306

