You Matter!

Wellness Credit Voucher

Employee Name _____ Department _____

Submit this form to the Commissioners' Office to receive credit for completion of the following Wellness Programs. (For the Community Sponsored Fitness Events, entry will be made once all five events have been submitted.) Those forms received by the quarterly deadline will be entered into the prize drawing for the quarter in which it was received. Program credit will not be provided for forms received after December 28, 2015.

☐ **Community Sponsored Fitness Event: Date of Event** _____

Program Sponsor Verification: I verify that the employee listed above participated in the following Community Sponsored Fitness Event.

Name of Event _____

Sponsored By _____

Authorized Signature _____
Printed results are also accepted in place of authorized signature.

☐ **Dining with Diabetes/Nutrition Education Counseling: Dates Completed** _____

Program Verification: I verify that the employee listed above completed the following nutrition counseling.

☐ OSU Dining with Diabetes (provide detailed receipt with dates attended)

☐ Nutrition Education Counseling Provided By _____

Provider's Signature _____

☐ **Volunteer Service: Dates Completed** _____

Program Verification: I verify that the employee listed above volunteered with our organization.

Amount of Time _____

Name of Organization _____

Authorized Signature _____

☐ **Employee Assistance Program/Counseling**

☐ Employee Assistance Program ☐ Other Provider (Printed Name) _____

Program Verification: I verify that the employee listed above utilized the Employee Assistance Program.

Provider's Signature _____

☐ **Doctor Verification of Wellness Awareness Screening: Date Completed** _____

Health Care Provider Verification: I verify that the employee listed above received a Comprehensive Annual Physical w/blood work which included the following tests: Cholesterol w/LDL, HDL, Triglycerides; Fasting Blood Sugar; Occult Blood Screening; Blood Pressure; Body Mass Index

In accordance with HIPAA regulations, we are not asking for the results of any of the above tests. We are asking you to simply verify that he/she has received age and gender specific preventive care which may be part of managing a disease state during the current calendar year. He/she will then be eligible to receive credit under our Wellness Program.

Health Care Provider's Signature _____

Health Care Provider's Name (Printed) _____

Health Care Provider's Address _____