4 South Eagleville Road
Mansfield, CT 06268

Be Well
An EHHD Wellness Program

EHHD
Eastern Highlands Health District

Employee fills out this section

Mansfield Employee Rewards Program
PREVENTATIVE HEALTH SCREENING VERIFICATION FORM

Employee's Name: _____Date of Appointment: _____

Health Care Provider's Name: _____

Health Care Provider's Address: _____

_____

Health Care Provider fills out this section

Instructions for Health Care Provider:

I certify that the above named person had the following:

_____exam/screen on the date indicated above.
(name of exam/screen conducted)

This screening was recommended by the health care provider due to the patient age, background, or health risk factor. Examples include but are not limited to mammography, metabolic syndrome, PSA, skin cancer screen, Bone Density test, Colonoscopy, Hemoglobin A1C, etc.

Be Well
Earn Points
Get Money
Be Well!
Rewards

_____ _____
Health Care Provider (HCP) Signature **Date**

Employee or HCP: Please fax, scan/email, or mail this form to Be Well
FAX: 860-429-3321 **MAIL:** 4 South Eagleville Rd. Mansfield, CT 06268
EMAIL: be_well@ehhd.org