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
VISION VERIFICATION FORM

Employee's Name: _____Date of Appointment: _____

Health Care Provider's Name: _____

Health Care Provider's Address: _____

_____

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Health Care Provider fills out this section

Instructions for Health Care Provider:

I certify that the above named person:

_____ Had a routine vision exam on the date indicated above.

_____ _____

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