4 South Eagleville Road
Mansfield, CT 06268

Employee fills out this section

Tolland Employee Rewards Program
Medical Verification Form

Please print clearly ...... we can't *use* the information if we can't *read* the information!

Date of exam: ________________

Employee's (or Spouse's) Name: __________________________________

Health Care Provider's Name: ____

Health Care Provider's Specialty: ____

Health Care Provider's Address: ____

____

Health Care Provider fills out this section

Instructions for Health Care Provider:
Please place your *initials* next to each statement that applies to this visit.

I certify that the above named person (an employee/spouse of the Town of Tolland):

_______ Received a physical exam (or annual gynecological exam) on the date indicated above.

_______ Had their Body Mass Index assessed on the date indicated above

_______ Had their blood pressure checked on the date indicated above

_______ Had their blood cholesterol levels checked on the date indicated above

_______ Had their blood glucose levels checked on the date indicated above

Comments:

____________________________________ ______________________

Health Care Provider Signature **Date**

Employee or Health Care Provider:

FAX: 860-429-3321 **Email:** be_well@ehhd.org **Mail**:4 S. Eagleville Rd, Mansfield, CT 06268

2018-2019