



Tolland Employee Rewards Program Medical Verification Form

	F	Please print		we can't					the inforr	mation!		
Date o	of exam:											
Emplo	yee's (o	· Spouse	's) Nam	э:							_	
Health	n Care Pi	ovider's	Name:									
Health	n Care Pi	ovider's	Specialt	y:								
Health	n Care Pr	ovider's	Address	:								
		ı	nstruct	ione f	r Hea	ilth C	are P	Provid	ler:			
Pleas	se plac					state	men	t that	appli	es to	this	visit.
	se place by that the	e your	initials I	next to	each							visit.
	fy that the	e your	<i>initials</i> i	n ext to erson (a	each	oyee/s	spouse	e of the	e Town	of Tol	lland):	
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Employee or Health Care Provider:

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