



An EHHD Wellness Program

4 South Eagleville Road
Mansfield, CT 06268



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: _____

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:



Employee fills out this section

Health Care Provider fills out this section