



# 2

## CHAMBERS COUNTY WELLNESS PROGRAM “ THE HEALTHY WEIGH OF LIFE” AFFIDAVIT OF COMPLETED WELLNESS ACTIVITY

**Note to Staff/Instructor** - Due to the nature of our wellness program, we ask that you please sign and fill out the information below. *Thanks!*

**ALL AFFIDAVITS ARE DUE IN THE WELLNESS CENTER WITHIN THIRTY (30) DAYS OF THE COMPLETED ACTIVITY.**

### Stress Management Activities

**Live Session (Limit of 3 per contract year)  
(includes Message Therapy—refer to page 4, section 6)**

An affidavit is only required for Non-County Sponsored Activities.  
Sign In Sheets for County Classes are used in place of affidavits.

\_\_\_\_\_  
**Session Name and Date**  
*Class Instructor Must Sign Below*

**Video or Book (Limit of 3)**

To receive wellness points for videos/books, fill out the fact table below.

\_\_\_\_\_  
**Title of Video/Book and Date Completed**

### Wellness Activities

**Live Class (Limit of 3)**

An affidavit is only required for Non-County Sponsored Activities.  
Sign In Sheets for County Classes are used in place of affidavits.  
Why Weight Program—guest speakers

\_\_\_\_\_  
**Class Name and Date**  
*Class Instructor Must Sign Below*

**Video or Book (Limit of 3)**

To receive wellness points for videos/books, fill out the fact table below.

\_\_\_\_\_  
**Title of Video/Book and Date Completed**

**Participation in a Wellness Focus Activity**

Witness signature required below.

\_\_\_\_\_  
**Focus Activity Name and Date**

### Video/Book Fact Table

Employees must list four facts learned from the video/book to receive credit.

1.	2.
3.	4.

*I have read the Wellness Program Reimbursement Procedures and Requirements. I hereby certify that I have fulfilled the Wellness Program individual items requirements for reimbursement for the activity (or activities) noted above. I understand that I can submit an affidavit form for each activity completed or for more than one activity at a time.*

\_\_\_\_\_  
**Employee Signature**

\_\_\_\_\_  
**Signature of Witness, Staff, Therapist or Instructor**

\_\_\_\_\_  
**Printed Name of Employee**

Department

\_\_\_\_\_  
**Printed Name of Witness, Staff, Therapist or Instructor**

\_\_\_\_\_  
**Date (please complete)**

\_\_\_\_\_  
**Address & Ph# of Witness, Staff, Therapist or Instructor**

*Note to Participant: Please retain a copy of this document for your records before sending the original to the Wellness Center. Also, for your convenience, we can accept forms faxed directly from the healthcare provider's office with either a business header from the fax machine or other proof of origin. Proof of Activity: This form completed by your physician or licensed health care provider, a copy of paid receipt (showing testing), copy of insurance claim (showing testing), or copy of EOB.*

