



1

CHAMBERS COUNTY WELLNESS PROGRAM “The Healthy Weigh of Life” AFFIDAVIT OF COMPLETED WELLNESS ACTIVITY

Note to Physician or Health Care Provider: Due to the nature of our wellness program please initial the first box that states “checked”, check marks are not acceptable. Then circle yes or no to determine whether the patient is in the healthy range of the test. Points available are listed next to each screening.

Health Care Provider Initials Required Below					
	Initials	Healthy		Initials	Healthy
Comprehensive Physical (50)		*****	Male: Prostate Exam/PSA (15)		*****
Weight (10)		Yes/No	Breast Exam or Mammogram (15)		*****
Diabetes Screening (fasting glucose) (10)		Yes/No	Colorectal Cancer Screening (stool for occult blood, or colonoscopy) (15)		*****
Blood Pressure (10)		Yes/No	Cervical Cancer Screening (15)		*****
Total Cholesterol (5)		Yes/No	Bone Density Screening (15)		*****
LDL (5)		Yes/No	Pulmonary Function Screening (15)		*****
Triglycerides (5)		Yes/No	Skin Cancer Screening (15)		*****
HDL (5)		Yes/No	EKG (15)		*****
Fitness/Health Professional Initials Required Below					
Flexibility Testing (Sit & Reach, etc.) (10)		*****	Body Composition (% Body Fat) (10)		*****
Muscular Strength (10)		*****	Body Mass Index (10)		Yes/No
		*****	Muscular Endurance (10)		*****
Dentist			Optometrist/Ophthalmologist		
Dental Cleaning/Exam (15)		*****	Eye Exam (15)		*****
Employee Initials Required Below					
Non-Smoker or User of Tobacco Products (Witness signature required below).			_____ I do not use tobacco products.		

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 Physician, Witness, Therapist or Instructor

Printed Name of Employee

Department Printed Name of Physician, Witness, Therapist or Instructor

Date (please complete)

Address & Ph# of Physician, Witness, 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.