



2010 Wellness Program Documentation Form Annual Eye Exam

Employee Name _____

The following is to document your receipt of an annual eye exam by an appropriate health care provider and/or facility. Please provide the required information below:

Health Care Provider/Facility _____

Location of Health Care Provider/Facility _____

Date of Service _____

In addition, attach a copy of the receipt from the health care provider/facility that administered the eye exam. Incentives/prizes are contingent upon the submittal of all required paperwork. By signing below, you acknowledge that you did receive a flu shot for yourself and that the documentation you are providing for yourself is valid and original.

Signature _____ Date _____

Note:

All private health information shared with the Premier Wellness Coordinator through your involvement in the program is strictly confidential. No other individual or entity will have access to this information without your expressed consent.