ATTESTATION FOR WELLNESS INCENTIVE

THE ORIGINAL FORM SHOULD BE RETURNED OR MAILED DIRECTLY TO:
CITY OF MILFORD HUMAN RRESOURCES DEPARTMENT
70 West River Street, Milford, CT 06460

ANNUAL ROUTINE PHYSICAL EXAM FORM

Each employee/spouse covered by a High Deductible Health Plan has been asked to have an annual routine physical examination performed during each plan year. This routine physical should consist of the items listed below **as deemed appropriate by the employee's/spouse's primary care provider.**

Once the exam is complete, please sign and date this form and return it to the patient so they may turn it in to Human Resources. You may also mail the form directly. Please do not fax the form – we need the original signature. Please provide the employee/spouse with biometrical results of their exam and lab work. They may use this information to complete an online Health Risk Assessment with Anthem.

The Routine Physical Exam May Include the Following:

- Preventive Physical Exam, which includes medical and family health history, assessment of lifestyle (diet, stress, exercise, etc.) general system examination (heart, lungs, throat, thyroid, ears, skin, joints, etc.) and measurement of height and weight
- Routine blood and urine screenings
- Cholesterol and lipid level screenings
- Blood glucose screening
- Eye chart vision screening
- Immunizations (tetanus every ten years, others as appropriate)
- Pelvic examination, Pap Smear, and Mammography screenings
- Prostate examination and prostate specific antigen blood test (PSA) *(males only)*
- Colorectal cancer screening

You, as the health care provider, will determine which one of several types of screenings is most appropriate and at what age it should be done.

I certify that I performed a routine physical exam on _____ and that the exam included appropriate screenings.

Patient's name: _____
Physician's Name: _____
Date of Physical: _____ - _____ - _____
Physician's Signature: _____