

Wellness Appointment Verification 2025/2026 Program Year

Miami County, Kansas



First Name:	Last Name:	Employee ID
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By my signature below, I affirm that I authorize my physician to verify that I have completed a wellness exam at my physician's office on the date indicated below.

Signature of Employee: _____ Date: _____

Miami County has implemented a wellness program to encourage our employees to live healthier lives by actively engaging with a health care provider and utilizing the preventative services available through the County health care benefit plans. Employees enrolled in a County health care plan must submit to an annual wellness screening in order to avoid a premium increase for the plan year.

This form must be submitted to Human Resources by 6/30/2026.

IMPORTANT NOTES:

- No Protected Health Information (PHI) and no results of any biometric screening or lab results shall be included on or attached to this form.
- To receive credit for completion, the wellness exam and a biometric screening must be completed between **7/1/2025 - 6/30/2026.**

TO BE COMPLETED BY PHYSICIAN:

I certify that the above-named patient completed an exam at my office on the following date: _____

Biometric lab work completed during this visit? ___ Yes / ___ No

If no, labs completed on: _____

Name of Physician (printed): _____

Address: _____

City: _____ State: _____ Zip Code: _____ Office Phone: _____

Physician Signature: _____ Date: _____