2016 Wellness Exam Certification Form

SECTION I: ***TO BE COMPLETED BY EMPLOYEE*** **(PLEASE PRINT)**

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Work Phone Number: _____Date of Birth: _____

I certify that the below is accurate to my knowledge and that if I knowingly falsify any documents relating to the wellness program, I will receive punishment, including possible termination. I understand it is solely my responsibility to follow up with my personal physician for results outside of the normal range or if I have any questions or concerns regarding my health.

Signature: _____Date: _____

SECTION II: ***TO BE COMPLETED BY EMPLOYEE'S PHYSICIAN.***

Date of Physical Examination:_____

I certify that I have worked with the patient listed above to provide the following care:

☐ Age appropriate preventive exam (i.e. annual physical, needed bloodwork, well woman exam, etc.)

Physician's Signature: _____

Physician's Name (please print): _____

Physician's Address: _____

Physicals performed by your personal physician must be completed between 11/01/2015 and 11/1/2016 to receive the incentive(s). This form should be returned to AMERISAFE, Inc. – Benefits Department, Attn: Rebekah Fontenot via: Email - rfontenot@amerisafe.com, Fax - 337-460-3685 or Mail: 2301 Hwy. 190 W., DeRidder, LA 70634. *Questions regarding this program should be directed to Rebekah Fontenot.*