**** Please print your name below, take to wellness screening provider to complete and sign, then return form to HR. Thank you!

ALLEGHANY COUNTY WELLNESS CERTIFICATION

NAME _____

PLEASE PRINT

Dear Medical Provider,

Thank you in advance for assisting Alleghany County administer its wellness program. For the individual named above, please check the boxes for the care provided and complete the bottom of the form. The named individual should return the completed form to Alleghany County HR Department.

MEN'S HEALTH

check box	☐	**ANNUAL WELLNESS EXAM**	**DATE** _____
check box	☐	**PROSTATE CANCER SCREENING**	**DATE** _____

WOMEN'S HEALTH

check box	☐	**ANNUAL WELLNESS EXAM**	**DATE** _____
check box	☐	**MAMMOGRAM**	**DATE** _____
check box	☐	**PAP TEST**	**DATE** _____
check box	☐	**not applicable**	

BOTH MEN AND WOMEN

check box	☐	**COLONOSCOPY / COLOGUARD**	**DATE** _____

PROVIDER NAME: _____

PROVIDER SIGNATURE: _____