dermalogica wellness
Healthy Living | Live it Daily

2018 Annual Physical Exam Certification

Date Submitted: _____Employee Name: _____

To Be Completed by Health Care Provider:

Dear Health Care Provider:

Your patient, _____ is participating in an employer-sponsored Wellness Program. One component of this program is completing an annual physical examination. The date of service for this physical examination must be between September 1, 2017, and September 1, 2018, in order to be eligible for a reward.

This is to certify that on the date indicated below, I, a licensed medical physician / a licensed physician assistant / or a licensed advanced nurse practitioner/ provided an annual physical examination for the individual indicated above.

_____
Date of Examination

_____ _____
Health Care Provider Signature Print Name of Health Care Provider

Name, Address, Telephone # of Health Care Provider:

Please Note: All medical information is CONFIDENTIAL and disclosure will only be made consistent with the Health Insurance Portability and Accountability Act of 1996 and state privacy laws.

To Be Completed by Employee:

Employee/Patient: I am providing the above certification to Dermalogica, LLC voluntarily and by signing below, I authorize Dermalogica, LLC to use the above information to confirm that I have met the criteria necessary to receive a reward. I fully understand that providing this information and participation in the Wellness Program is voluntary, and that I freely provide the above certification from my health care provider.

_____ _____
Employee/Patient Signature Date

Completed Form Must Be Submitted to HR by September 4, 2018