Employee Wellness Incentive Credit Form

(Please Print and Complete Entire Top of Form)

Legal Name: _____Date: _____

Email: _____

Phone Number you can be contacted: _____

What you have done for wellness point (Have person verifying the procedure or point sign this form or attach any documents required to this form):

_____

_____

Write what the point is for above or check the appropriate box below.
Each incentive opportunity must be signed off on to receive credit. Note some of these are based on gender and age restrictions.
(Please make sure to consider the current healthcare standards and age restrictions for coverage)

- ☐ **Full Wellness/ Yearly Physical** (Note: County offers copay free lab draws with doctors' orders)
  Signature of Provider completing: _____ Date completed: _____
- ☐ **GYN exam with pap/ without pap**
  Signature of Provider completing: _____ Date completed: _____
- ☐ **PSA/ Manual Prostate exam done at specialist or PCP** (PSA can be done in clinic for free)
  Signature of Provider completing: _____ Date completed: _____
- ☐ **Mammogram** (preventative/ diagnostic)
  Signature of tech completing: _____ Date completed: _____
- ☐ **Bone Density**
  Signature of tech completing: _____ Date completed: _____
- ☐ **Whole Body Skin check** (Must be completed by a specialist in Dermatology only)
  Signature of tech completing_____ Date completed: _____
- ☐ **Colonoscopy** (preventative/ diagnostic)
  Signature of specialist completing: _____ Date completed: _____
- ☐ **Flu shot done at PCP or local pharmacy** (note only ½ when not done in clinic)
  Signature of person giving: _____ Date completed: _____
- ☐ **Dental Exam** – Full preventative exam and cleaning- (Not for restorative dental work)
  Signature of Provider completing: _____ Date completed: _____
- ☐ **Eye Exam** – Full yearly preventative exam (Not for treatment of acute eye conditions)
  Signature of Provider completing: _____ Date completed: _____
- ☐ **Covid Vaccine** – Must attach copy of original vax card. (Not for boosters, only original series).
  Copy attached ____ Date completed: _____

Office Use Only:
Date approved ____/____/____
Entered into WS
_____/_____/_____ by ____ total of points
entered using this sheet _____.

For incentive credit:
Completed form must be returned to
Misty White, RN – Wayne County Employee Health Clinic – 330-287-5487
428 W. Liberty St., Wooster, OH 44691 or faxed to 330-262-2054
by the November 15th Deadline. You can use for several points on the same page or a separate page for each point. It is not recommended to hold on to get each thing checked off but turn in when completed and do not hold.

Revised 10/29/25