Town of East Hartford Attestation for Wellness Incentive Form

THE ORIGINAL DOCUMENT MUST BE SUBMITTED DIRECTLY TO THE HUMAN RESOURCES OFFICE:
Terry Jones, Benefits Manager
740 Main Street
East Hartford, CT 06108
HRINFORMATION@EASTHARTFORDCT.GOV

ANNUAL ROUTINE PHYSICAL EXAM FORM

Each employee covered by a **Town of East Hartford High Deductible Health Plan** has been asked to have an annual routine physical examination performed during the plan year. This routine physical should consist of the items listed below, as deemed appropriate by the employee's primary care provider.

Once the exam is complete, please sign and date this form and return it to the patient so they may turn it in to HR. **Please provide the employee with biometrical results of their exam and lab work. They may use this information to complete an online Health Risk Assessment with Anthem.** Employees may hand deliver, interoffice or email the form directly to the Human Resources Office at **HRInformation@EastHartfordct.gov.**

The Routine Physical Exam Should Include the Following:

- Preventive Physical Exam, which includes medical and family health history, assessment of lifestyle (diet, stress, exercise, etc.) general system examination (heart, lungs, throat, thyroid, ears, skin, joints, etc.). and measurement of height and weight
- Routine blood pressure and urine screenings
- Cholesterol and lipid level screenings
- Blood glucose screening
- Eye chart vision screening
- Immunizations (tetanus every ten years, others as appropriate)
- Pelvic examination, Pap Smear, and Mammography screenings
- Prostate examination and prostate specific antigen blood test (PSA) (*males only*)
- Colorectal cancer screening

You, as the health care provider will determine which one of several types of screenings is most appropriate and at what age it should be done.

I certify that I have performed a routine physical exam on Town of East Hartford employee and that this employee has had all appropriate screenings:

_____
Please Print Employee Name Clearly

Physician's Name: _____

Date of Physical: _____

Physician's Signature: _____