Proof of Visit/Verification Form

Please attach this sheet to your Wellness Rewards Form and return to the Benefits Department **no later than 12/31/2026.**

Employee Name (please print): _____

Preventive Visit

This proof of visit confirms that the patient named above received **one** of the following preventive care services (you do **not** need to indicate which service):

- Routine Preventive Wellness Check-Up
- Mammogram
- Pap Smear
- Colonoscopy
- Skin Cancer Check
- Dental Exam

Physician Verification

Physician Office/Name: _____

Date of Visit: _____

Physician/Dentist Signature: _____ Date: _____

Patient/Associate

I authorize the release of this proof of visit to Woods Services. I understand that Woods will not receive any personal information regarding these preventive services from my doctor or any other third party. Only my participation has been verified.

Patient Signature: _____ Date: _____