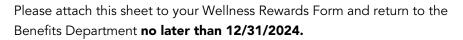
Proof of Visit/Verification Form





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

participation has been verified.

Physician Office/Name:

Date of Visit:	
Physician/Dentist Signature:	Date:
Patient/Associate	
·	s Services. I understand that Woods will not receive any vices from my doctor or any other third party. Only my

Patient Signature: _____

Activity/Blood Pressure Log



Please attach this sheet to your Wellness Rewards Form and return to the Benefits Department **no later than 12/31/2024.**

Employee Name (please print):	
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Fitness Verification/Self-Report Log

- **1. Walking Option:** Walk 30 minutes. Please record the dates that you walk in 2024 on the log below (at least 50 entries required). Examples include walking to and from bus, walking pets, or any activity that keeps you moving!
- **2. Gym/Fitness Class Option:** Request a visit log from your gym and attach to your signed form. If your gym cannot provide a printout, please write down the class and date in the 50 spots provided below.

ACTIVITY/DATE	ACTIVITY/DATE	ACTIVITY/DATE
1	18	35
2	19	36
3	20	37
4	21	38
5	22	39
6	23	40
7	24	41
8	25	42
9	26	43
10	27	44
11	28	45
12	29	46
13	30	47
14	31	48
15	32	49
16	33	50
17	34	

Blood Pressure Log

Take your blood pressure once each month (at least 3 months) and fill-out the information below. Please do not record your actual blood pressure reading on this sheet.

MONTH	LOCATION OF BP READING	DATE RECORDED	
			_
			_
I attest the self-reported information	on above is true and accurate.		
Employee Signature:		Date:	

Nutrition Counseling / Mindfulness Activity Verification



Please attach this sheet to your Wellness Rewards Form and return to the Benefits Department **no later than 12/31/2024.**

Employee Name (please print):

Dietitian Visit			
•	ns that the employee named al n counseling visit on the follow :		(2)35
Date 1:	Date 2:	\	
Dietitian Office/Name: _			الل الله
Dietitian Signature:			
personal information reg Only my participation ha	this proof of visit to Woods Se arding my nutrition counseling s been verified.	visits from my dietitian or a	any other third party.
Employee Signature		Date	
Mindfulness Activ I completed a Mindfulne or yoga class)	ity ss Activity at least three times (meditation, stress reductio	n seminar/ counseling,
Date 1:	Date 2:	Date 3:	
I attest the self-reporte	ed information above is true a	nd accurate.	
Employee Signature:		5.	

Volunteering Activity Verification



Please attach this sheet to your Wellness Rewards Form and return to the Benefits Department **no later than 12/31/2024.**

Employee Name	(please print):	
	'I I '	

Volunteering for a Local Charity

This proof of visit confirms that the employee named above volunteered for a local charity for a minimum of two hours on the following dates (limit **two**):

Date 1:	Date 2:
Name of event:	Name of event:

