WELLNESS SCREENING VERIFICATION FORM

USD #307 - Ell-Saline Public Schools

Please have this form completed and signed by your healthcare provider to verify that you completed these preventative services. Return this form to Cher Richards at the District Office by mail or by email to USD #307 - Ell-Saline, PO Box 157, Brookville, KS 67425 or crichards@ellsaline.org.

SECTION A: MEMBER INFORMATION - PLEASE PRINT

FIRST NAME:	LAST NAME:
MEMBER SIGNATURE:	DATE (MM/DD/YYYY):

SECTION B: PROVIDER INFORMATION - PLEASE PRINT

DOCTOR/PRACTICE/FACILITY NAME:	
ADDRESS:	PHONE NUMBER

SECTION C: CATEGORIES SCREENED - CHECK THE BOX OF THE PREVENTATIVE SERVICES PERFORMED

Date of Exam (MM/DD/YYYY):			**DO NOT INCLUDE RESULTS**
☐ Height	☐ A1C/Blood Sugar	☐ Blood Pressure	
☐ Weight	☐ Triglycerides	☐ Cholesterol	

REQUIRED TESTS TO BE PERFORMED SHOULD BE COVERED UNDER THE PREVENTATIVE SERVICES PORTION OF THE AFFORDABLE CARE ACT.

SECTION D: CERTIFICATION OF RESULTS - PLEASE PRINT

I certify that this member has had the preventative services as indicated in Section C.

FIRST NAME:	LAST NAME:
TITLE:	
PROVIDER'S SIGNATURE:	DATE (MM/DD/YYYY):

PLEASE RETURN THIS FORM BY JANUARY 1ST TO THE ELL-SALINE DISTRICT OFFICE.