# Activity Authorization Form
# Be Well Rewards Program

**Medical Professional Instructions**

*Dear Medical Professional,*

*As part of the Be Well wellness program initiative, benefit eligible employees have been asked to participate in various routine **preventative** health visits. The Be Well program is not requesting any records or personal health information pertaining to these visits. Once the corresponding visit is complete, please sign, date, and return this form to our employee, so they may turn it in to the Be Well program as confirmation.*

** Please inform the employee that if other tests/services are performed, the employee may be responsible for out-of-pocket costs based on their insurance plan.*

*Sincerely,*
*Be Well Program*

---

**Using separate copies of this sheet, please have the appropriate medical professional sign off for each visit.**
**** Please hold onto all copies from individual visits to turn in at the end of the year.**

Type of Visit: _____
(Vision, dental, physical, spouse/child, flu shot, *other* preventative screening)

Name: _____
Signature: _____
Date: _____

---

**Employee Information & Release**

I_____(print employee name) authorize_____(medical professional's name) to release the dates of my routine physical exam, as specified on this form for the Be Well program.

I understand participation in the Be Well program is voluntary, and that this is for a preventative wellness exam. If other tests/services are performed, I will be responsible for out-of-pocket costs based on my insurance plan.

Employee Name (Print):_____ Employee Signature:_____