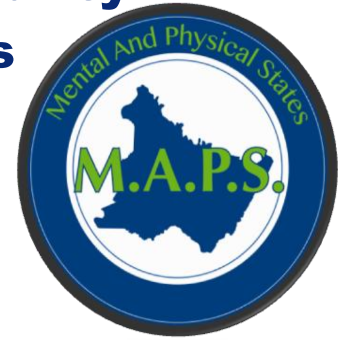
Westmoreland County
Human Resources



WELLNESS QUALIFICATION VERIFICATION FORM

Complete and submit this form to the Human Resources Office by August 31, 2019 for the 2020 M.A.P.S. qualification or re-certification period. New Hires must submit within 45 days of insurance qualification for 2019 and 2020.

Qualification requirements include the completion of a wellness exam, one (1) preventative activity and one (1) wellness activity as outlined on the 2020 qualification flyer. Both employee & spouse must complete qualifications. Employee may submit supplemental documentation as verification of activity in place of physician verification. Please note the activity on this form and attach documentation.

Employee Name: ______________________________ Department: ___________________________

Phone Number: _________________________ Email: _____________________________________

Insurance: ☐UPMC ☐Highmark

Employee Qualifiers:

Wellness Exam

Date of Exam: _____________________ Blood Work Completed ☐Yes ☐No

Physician Name: ____

Physician Address: ____

____

Physician Phone Number: __________________________________

Physician Signature: ____

2 North Main Street
Suite 108
Greensburg, PA 15601

Phone: 724-830-3197
wellness@co.westmoreland.pa.us
www.co.westmoreland.pa.us

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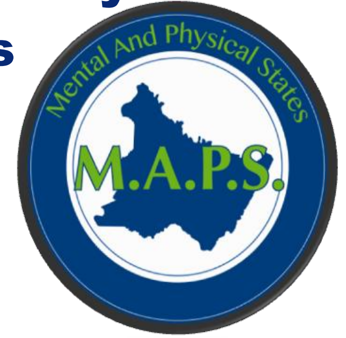

Employee Qualifiers:

Preventative Activity

Date Activity Completed: ____________________

Check Activity:

- ☐ *Vision Exam*
- ☐ *Dental Exam*
- ☐ *Gynecology Exam*
- ☐ *Mammogram*
- ☐ *Flu Shot*
- ☐ *Colonoscopy*
- ☐ *Bone Density Screening*
- ☐ *Health Risk Assessment*
- ☐ *Real Age Test (sharecare.com)*

Medical Provider Verification of Activity:

Physician Name: ____ Phone #: ________________

Physician Address: ____

____

Physician Signature: ____

Employee Qualifiers:

Wellness Activity

Date Activity Completed: ____________________

Check Activity:

- ☐ *Enrollment in a weight loss program*
- ☐ *Enrollment in a dietetic program*
- ☐ *Attend a Lunch & Learn*
- ☐ *Attend the 2019 Wellness Fair*
- ☐ *Enroll in smoking cessation*
- ☐ *Participant in a sports league: participant or coach (6 week min)*
- ☐ *Active participation in Fitness Center or certify 30 Minutes of activity3x weekly*
- ☐ *Contact Insurance Health Coach*
- ☐ *Complete a charitable walk, run, swim or bike*
- ☐ *Participate in 2019 Pedometer Challenge*

Attach a copy of the certificate of completion, receipt, or event flyer/program you completed to this form. Also attest below that you have completed the documented activity. (Health Coach Contact will only require the below attestation)

Signature: ____ Date: ____________________

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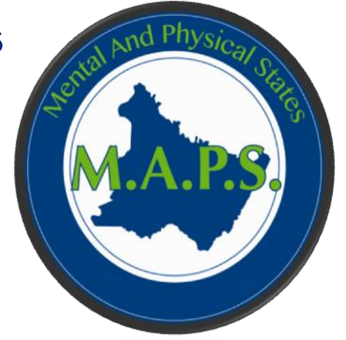

Spouse Qualifiers: **Check if not applicable** ☐

Spouse Name: ______________________________

Phone Number: ______________________________

Wellness Exam

Date of Exam: ______________________ Blood Work Completed ☐Yes ☐No

Physician Name: ______________________________________

Physician Address: ______________________________________

____

Physician Phone Number: ______________________________

Physician Signature: ______________________________________

Preventative Activity

Date Activity Completed: ______________________

Check Activity:

- ☐ *Vision Exam*
- ☐ *Dental Exam*
- ☐ *Gynecology Exam*
- ☐ *Mammogram*
- ☐ *Flu Shot*
- ☐ *Colonoscopy*
- ☐ *Bone Density Screening*
- ☐ *Health Risk Assessment*
- ☐ *Real Age Test (sharecare.com)*

Medical Provider Verification of Activity:

Physician Name: ______________________________________ Phone #: ________________

Physician Address: ______________________________________

____

Physician Signature: ______________________________________

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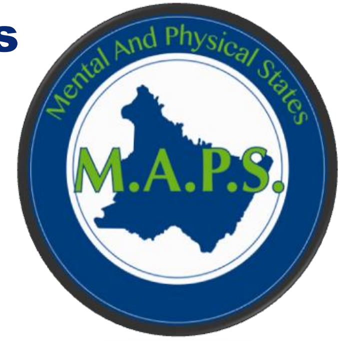

Spouse Qualifiers:

Wellness Activity

Date Activity Completed: ____________________

Check Activity:

- ☐ *Enrollment in a weight loss program*
- ☐ *Enrollment in a dietetic program*
- ☐ *Attend a Lunch & Learn*
- ☐ *Attend the 2019 Wellness Fair*
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Attach a copy of the certificate of completion, receipt, or event flyer/program you completed to this form. Also attest below that you have completed the documented activity. (Health Coach contact will only require the below attestation)

Signature: ____ Date: ____________________

Date Submitted to Human Resources: ____________________________

Employee Signature: ____

Human Resources
Representative Signature: ____

For completion of Human Resources:

Date entered into the system: ____________________________________

Employee entering: ____

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