ANNUAL PHYSICAL FORM

Member Name: _____

UHC Member ID # _____

Employer: City of Little Rock

The above referenced member is my patient. He/She completed an Annual Physical which included a biometric screening on _____.

Physician's Signature: _____ Date:_____

Employee's Signature: _____ Date:_____

Physician's Name and Office Location:

_____

_____

_____

_____

Please return this form to:
City of Little Rock
Benefits Division
500 W. Markham Suite 130W
Little Rock, Arkansas 72201
Fax: (501) 371-4496
HRBenefits@littlerock.gov

As a participant in the City of Little Rock's Wellness Program I am required to have an Annual Physical that includes a biometric screening. The Annual Physical has to be completed between July 1, 2017 and June 30, 2018.