ANNUAL PHYSICAL FORM

Member Name: __________________________________

Employee 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:

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

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, 2018 and June 30, 2019.