ANNUAL PREVENTATIVE CARE EXAM FORM

Member Name: ____

Employee #: ____________________

Employer: City of Little Rock

The above referenced member is my patient and completed an Annual Preventative Care Exam on (mm/dd/yyyy) ____________________.

Physician's Name and Office Location:

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Physician's Signature: __________________________________ Date: ____________________

As a participant in the City of Little Rock's Wellness Program I am required to have an Annual Preventative Care Exam. The Annual Preventative Care Exam has to be completed between January 1, 2021 and December 31, 2021.

Employee's Signature: _________________________________ Date: ____________________

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