



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:

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
