HEALTHY WEIGHT VERIFICATION FORM

All information will remain confidential

NAME_____ PHONE #_____
E-MAIL_____

**This will count for 2 wellness points if your BMI is over 27 and you lose 10 or more pounds.*
Start Date and End Date must be between January 1st and December 31st

START DATE _____ BMI_____ WEIGHT_____

END DATE _____ BMI_____ WEIGHT_____

PHYSICIAN/RN/MEDICAL ASSISTANT

_____ Signature _____ Date