CITY OF PASADENA
PLAN YEAR 2021 - 2022
WELLNESS PROGRAM

AFFIDAVIT OF ANNUAL PERSONAL HEALTH ASSESSMENT

Patient's Printed Name: _____ Date: _____

The intent of this affidavit is to confirm that a PERSONAL HEALTH ASSESSMENT was conducted for the above named individual during the 2021 calendar year.

Health Care Provider – we do not require the test results, we only need to know that the assessment was completed.

Personal Health Assessment Elements

- **Blood Pressure**
- **Height / Weight**
- **Complete Metabolic Panel (CMP 14)**
- **Lipid Panel with TC: HDL Ratio**

_____ _____

SIGNATURE OF HEALTH CARE PROVIDER **PRINTED NAME OR STAMP OF HEALTH CARE PROVIDER**

I, the undersigned City Employee / Spouse hereby certify that I have fulfilled the above requirements in order to receive a discounted contribution rate for my employer provided medical insurance.

_____ _____

SIGNATURE OF PATIENT (EMPLOYEE / SPOUSE) **PRINTED NAME OF CITY EMPLOYEE ON INSURANCE**

Date: _____, 2021