Creative Foam Corporation

Preventative Care

Submission Form

Employee Information

Employee #: _____

Name: _____

Location: _____

Please check the applicable Preventative Care:

☐ Annual Physical

☐ Dental Cleaning/Exam

☐ Colonoscopy

☐ Eye Exam

☐ Hearing Test

☐ Other (Specify): _____

To Be Completed By Doctor:

I certify that Preventative Care was completed for the above named

individual on: _____ / _____ / _____
month day year

Printed Name of Doctor: _____

Address: _____

_____

Dr. Signature: _____

Date_____

***Appt must be completed less than (1) year prior to the date of submission.**

Form will be applied to the quarter in which it was received unless 50 points has already been reached with other activities. In those cases, it will be applied to the following quarter.

***Please return the completed form to your local Human Resources representative or fax/email to the Corporate Benefits Dept at 810-750-7613 / wellness@creativefoam.com.**