ALBUQUERQUE PUBLIC SCHOOLS Benefits Department
Employee Wellness
Promoting a Culture of Health

Physician Engagement Form

STEP 1. TO BE COMPLETED BY EMPLOYEE, SPOUSE/DOMESTIC PARTNER

If you AND your spouse/domestic partner are enrolled in the **APS medical plan**, then *each of you* will need to complete your own copy of this form.

(Please Print)

Last Name:_____ **First Name** _____

Choose One: ☐ Employee ☐ Spouse ☐ Domestic Partner

APS Employee ID#: _____

NOTE: If you are the **spouse/domestic partner** of an APS employee, write the ID# of the APS employee).

Last 4 SS#:_____**DOB:** _____
Month Day Year (XXXX)

Email Address: _____ **Phone:** _____

Signature: _____ **Date:** _____
(By my signature above, I certify that the information I provided on and in connection to this form is true, accurate and complete.)

Spouse/Domestic Partner ONLY:

If you are the **spouse/domestic partner** of an APS employee, please list the **employee's name** below.

APS Employee Name: _____

Do not write below this line

STEP 2. TO BE COMPLETED BY PROVIDER'S OFFICE. NOTE: ALL FIELDS MUST BE COMPLETED.

Exam must be performed between **October 1, 2017 – September 30, 2018**.

☐ Annual Preventive Exam Completed (check box if completed)

Date of Exam: _____/_____/_____

Healthcare Provider/Verifier Name (Printed): _____

Healthcare Provider/Verifier Signature:_____

Signature Date: _____/_____/_____ **Office Telephone Number:** _____

Exam date and type may be verified with physician's office.

STEP 3: TO BE COMPLETED BY APS EMPLOYEE OR SPOUSE/DOMESTIC PARTNER

Prior to Wellness Campaign Dates (**July 1, 2018– September 30, 2018**) – Keep this document in a safe place. **Recommendation**: Scan/Take a photo of document and send to your personal email. Once the campaign starts, you will need to submit a picture/scanned version of this form to your wellness portal. Watch for instructions in the Perspective and on the Employee Wellness website for additional information.