



Documentation of Preventive Practice

Please complete this document and have it signed by a healthcare practitioner as simple evidence of participation in a preventive practice for WellPath Points.

Please Do NOT provide personal/protected health information on this form. **Note:** Only *Grade A* preventive practices as determined by the U.S. Preventive Services Task Force, the Centers for Disease Control and Prevention and/or the Patient Protection and Affordable Care Act may be accepted for WellPath Points. Please see the prevention page of www.wellpath.info for details.

Employee Name: _____

Employee ID number: _____

Date of Service: ____/____/____

Preventive practice: _____

Employee signature: _____

Healthcare practitioner signature: _____