CLINICIAN VERIFICATION FORM

Instructions

After completing the **Member Information** and **Information Release** sections of this form, please have your clinician complete the **Clinician Information** and **Record** sections.

Once all sections are completed, please visit the Bulletin Board in your Wellable account for instructions on how to submit the form. If you have any questions, please reach out to Wellable Support.

Member Information

First Name	Last Name
Phone	Email
Company/Organization	

Information Release

I hereby authorize the individual and organization specified in the **Clinician Information** section to release the dates of my routine physical exam and/or flu shot to Wellable, LLC. I understand participation in my organization's wellness program is voluntary. If other tests or services are performed, I will be responsible for out-of-pocket costs based on my health insurance plan.

Member Name _____ Member Signature _____

Clinician Information

First Name	Last Name
Phone	Email
Practice/Organization	

Record

Service Date	Service(s) Performed	☐ Annual Physical	☐ Flu Shot

Clinician Name _____ Clinician Signature _____