Rutherford County Wellness Point Certification

Patient to Complete:

Employee Name: ______________________________ Employee Date of Birth: ______________

Patient Name: _________________________________ Patient Date of Birth: ________________

I authorize _______________________ to release the information contained on this form about my visit on
Provider's Printed Name
________________ to Rutherford County Insurance & Risk Management for use in calculating my wellness
Date of Visit
points. I understand that this information will not be used for any other purpose.

____ ______________________

Patient's Signature Date

Provider to Complete:

I hereby certify that __________________________________ was seen in my office on _______________
Patient Date of Visit
and completed the below service(s):

- ☐ Routine Physical Examination
- ☐ Colon Cancer Screening
- ☐ Prostate Screening
- ☐ DOT Physical Examination
- ☐ Mammogram
- ☐ Vision Exam
- ☐ Biometric Screening (lipid, glucose)
- ☐ Cervical Cancer Screening
- ☐ Dental Cleaning
- ☐ Flu Shot
- ☐ Annual OBGYN Woman's Health Examination

Provider Name: ______________________________________ Provider Phone: ___________________

Provider Address: ____

Authorized Representative: __________________________________ Title: _______________________

Authorized Representative Signature: ___________________________ Date: _______________________

Please submit form to the **Rutherford County Insurance & Risk Management** department
via email to benefits@rutherfordcountytn.gov or fax to 615-713-3451. For questions, please call 615-898-7715.

Revised 2/18/2026