



**Meyer Tool, Inc. WellLiving
Wellness Screening Confirmation Form**

Patient Name: _____

*Employee Number (required) _____ DOB _____

Patient MB number: _____ (on Medben ID card)

Physician Name: _____ Office Phone: _____

I certify the following screenings were performed on the dates listed:

Last Date screening

___/___/___ Annual Wellness Examination (Yearly beginning at 18)

___/___/___ Cholesterol Lipid Profile (Every 5 years beginning at 20)

___/___/___ Females – pap smear (Every 3 years beginning at 21-29)
(Every 5 years beginning at 30)

___/___/___ Females – mammography (Every 2 years beginning at 40)

Males & Females 45 & over:

___/___/___ Colonoscopy (Every 10 years beginning at 45)

Signature of Physician

Date

Please fax completed form to:

Meyer Tool Inc

Attn: HR

Fax No.: 513-853-4495

Or give to:

Deanna Adams

In HR