OZARKS COMMUNITY HEALTH CENTER
MEDICAL • DENTAL • BEHAVIORAL HEALTH

# EMPLOYEE HEALTH FORM

GetFIT PROGRAM

**DATE:**_____/_____/_____

**EMPLOYEE:**

FIRST NAME:_____ LAST NAME:_____

**HEALTH SERVICE:**

- ☐ Yearly Check-Up
- ☐ Mammogram
- ☐ Colonoscopy

*If you are a part of the Weight Loss Program, please see your Clinic Manager for more information.

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|---|---|
| **EMPLOYEE SIGNATURE:** | **DATE:** |
| **MEDICAL PROVIDER SIGNATURE:** | **DATE:** |