

WakeMed Health & Hospitals
SPOUSE SCREENING FORM

This form provides proof that a spouse physical was completed in this calendar year. This form must be submitted by December 31st to avoid the \$20/week spouse surcharge beginning in January of next year. To receive credit, please fill form out **COMPLETELY** and submit it via secure email, fax or mail to:

Email: MobileWellness@wakemed.org **Mail:** Liza MacDonald, Corporate and Community Health
3000 New Bern Ave.
Fax: 919-350-6739 Raleigh, NC 27610

Questions? Contact Liza MacDonald (se habla español) at MobileWellness@wakemed.org or 919-350-5909.

Patient Name: _____ DOB: _____

Patient Phone Number: _____

Patient Email: _____

FSC Employee Name: _____

FSC Employee DOB: _____ FSC Employee ID: _____

By signing this document, I certify that the above named individual has completed an annual physical.

Date of Physical: _____

Provider Name and Phone Number: _____

Signature of Provider: _____ Date: _____