TOBACCO CESSATION PROGRAM VERIFICATION FORM

SECTION I: ***TO BE COMPLETED THE OCU EMPLOYEE*** **(PLEASE PRINT)**

Name: _____

Date of Birth: _____ Aetna ID number: _____

I certify that the below is accurate to my knowledge and that if I knowingly falsify any documents relating to the wellness program, I will receive punishment, including possible termination. I understand it is solely my responsibility to follow up with a personal medical provider should questions or concerns regarding my health arise.

Signature of OCU employee named above: _____ Date: _____

SECTION II: ***TO BE COMPLETED BY YOUR HEALTH CARE PROVIDER OR IN-PERSON CESSATION PROGRAM LEADER/COUNSELOR.***

I certify that I have worked with the Oklahoma City University employee listed above to provide at least four sessions of an in-person tobacco cessation program or counseling within a 60-day timeframe.

Beginning and Ending dates of cessation appointments/sessions: _____

Cessation Provider's Signature: _____

Cessation Provider's Name (please print): _____

Cessation Provider's Business Address: _____

_____

_____

This completed form should be returned to ***Oklahoma City University.*** *Please submit this form to Human Resources, in person, by mail, campus mail, email to vrobinson@okcu.edu or fax to 405.208.6041.*

Oklahoma City University
Human Resources
2601 N. Blackwelder, AD 105
Oklahoma City, OK 73106

Questions regarding the OCU tobacco surcharge program may be directed to Valerie Robinson, Human Resources at vrobinson@okcu.edu or 405.208.5983.