

**AGH Integrative Health Therapies  
Verification Form  
2023 – 2024 Wellness Cycle**



Atlantic General Hospital  
Associates • Getting • Healthy  
Wellness Program

**Part 1: To be Completed by Employee (please print):**

Employee Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Employee ID#: \_\_\_\_\_

Employee Email: \_\_\_\_\_

**Part 2: To be Completed by Licensed Provider : (please print or use office stamp):**

I hereby confirm that the **AGH** employee above has completed the following **between 9/1/23 and 8/31/24:**

- |  |   |
|--|---|
| <input type="checkbox"/> Acupuncture (10 Points)   | <input type="checkbox"/> Nutritional Consultation (10 Points)   |
| <input type="checkbox"/> Massage (10 Points)       | <input type="checkbox"/> Chiropractic Therapy (10 Points)   |
| <input type="checkbox"/> Reflexology (10 Points)   | <input type="checkbox"/> EAP Counseling (10 Points)   |
| <input type="checkbox"/> Reiki (10 Points)         | <input type="checkbox"/> Medication Synchronization at AGHRx RediScripts<br>Pharmacy ("RediSync") - 10 Points |
| <input type="checkbox"/> Sound Therapy (10 Points) | <input type="checkbox"/> OTHER _____  |
| <input type="checkbox"/> Salt Therapy (10 Points)  |   |

\*Exercise therapy may be recorded as a self reported activity on your secure health portal

**You may receive credit for each item three (3) times per cycle.**

Licensed Provider's Name: (please print): \_\_\_\_\_ Date \_\_\_\_\_

Licensed Provider's

Office Address and Phone: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Licensed Provider's Signature: \_\_\_\_\_

**Part 3: To be Completed by Employee**

Please mail, fax, or email completed form to:

Name: BHS

Address: 6225 Smith Avenue, Suite 203, Baltimore, MD 21209

Fax: 410-878-6192      Email: [coach@bhsonline.com](mailto:coach@bhsonline.com)

Online: Forms may be uploaded to your secure health portal

Questions? Concerns? Contact BHS at 877-935-5262