



Caregiver Wellness Tobacco Cessation Attestation

Caregiver Name: (**Please Print**) _____

Caregiver ID Number: _____

Home/Cell Phone: _____

Name of program or method utilized: _____

Tobacco Cessation Date: _____

PLEASE INITIAL METHOD(S) USED

- Tobacco cessation program
- "Cold Turkey" (quit without assistance)
- Partnership with a licensed practitioner

By signing this form, you are attesting that you (or covered significant other) no longer use tobacco products and have not used them for a minimum of 30 days prior to today's date.

EMPLOYEE/Spouse Signature: _____

Please email completed form to employeewellness@integrishealth.org