U.S. Department of the Interior
Bureau of Reclamation
Human Resource Policy

Wellness Program Individual Wellness Agreement
Appendix A

Individual Wellness Agreement

This form is <u>required</u> for enrollment in the Reclamation Wellness/Fitness Program.

To be completed by EMPLOYEE

Employee's Name:_____ Org/Office/Unit:_____

My Work schedule is:

◯ Full-Time
(80 hours per pay period)

◯ Part-Time:
(Regularly scheduled hours per pay period)

◯ Seasonal:
(Number of guaranteed pay periods)

<u>Wellness Program/Fitness Activity(s)</u>. List the anticipated fitness activities or programs you will be participating in on a regular and recurring basis:

The anticipated cost for above wellness/fitness activity or program fees will be $_____ per _____.

<u>Program/Activity schedule</u>. Describe anticipated attendance and participation frequency:_____

<u>Program Election</u>: Read and acknowledge each of the following program requirements:

- I am electing to participate in the Reclamation's Employee Wellness Program reimbursement of allowable expenses not-to-exceed an annual reimbursement of $_____ with an _____% employee cost share. I understand that if I am on a part-time or part- year work schedule, reimbursement will be prorated based on the amount of time I work.
- I understand that wellness reimbursement is at supervisory discretion and based on my office's funding/budget.
- I agree to regular and recurring participation in the fitness program activities or wellness program(s) noted above.
- I agree to submit timely required documentation for eligible fitness activities as outlined in the Wellness Policy (HRM 04-12) for reimbursement.
- I have read and understand the provisions and requirements of the Reclamation Wellness Policy (HRM 04-12) and local Wellness Program provisions and requirements.
- I agree to abide by all conditions and requirements of the Reclamation Wellness Program D&S (HRM 04-12) and local Wellness Program.
- I am personally responsible for payment of all costs associated with my enrollment in approved fitness programs, activities, or services and that I may reimbursed only for authorized expenses to maximum allowable limits.
- If I fail to comply with these requirements, this agreement may be limited or terminated by my supervisor.
- I have provided a Wellness Screening Questionnaire (self-certification) and/or Medical Authorization to my supervisor.
- This Agreement is valid for one year (1) and must be renewed to continue to participate.
- Any changes to this agreement must be approved by my supervisor in advance.

I have read and understand the above wellness program requirements and provisions and voluntarily elect to participate.

_____	_____	_____
Employee (Type or print name)	Signature	Date

To be completed by Supervisor

REQUEST IS: ◯ Approved ◯ Denied (Please explain if limited, modified, or disapproved):

_____	_____	_____
Supervisor (Type or print name)	Signature	Date