Instructions for Receiving Your Health Screening
With Your Personal Physician

We are pleased that you are participating in the health screenings this year. Participation in the health screening is confidential. Please review these instructions to ensure that your information is complete and sent to the correct location.

See your primary care physician
1. Call your physician to schedule an appointment for your screening.
2. Fill out the Participant Information section of the Data Form.
3. Leave the Data Form with your doctor, and instruct the doctor to fill out the Body Measurements & Biometric Results section of the form.
4. Let the clinic/doctor know that the completed form must be faxed by February 29, 2016 to:

   | Wellness Corporate Solutions  
   | Attn: Information Management  
   | SECURE FAX: 888-349-1986  

Screening results obtained on or after March 1, 2015 may be used to complete the data form. Regardless of screening date, your physician must sign the form. Please fax the form only after all applicable testing has been completed.

ALL RESULTS MUST BE ENTERED INTO THE APPROPRIATE BOXES ON PAGE 2 OF THIS FORM. SEPARATE FORMS CANNOT BE REVIEWED OR PROCESSED.

If you have any questions please contact HPUwellness@wellnesscorporatesolutions.com.
DATA FORM FOR HEALTH SCREENING WITH YOUR PERSONAL PHYSICIAN

PARTICIPANT: Complete participant information, bring form to provider for completion.
Retain a signed copy for your records.

PROVIDER: Complete Body Measurements & Biometric Results and sign the form.
FAX completed form to Wellness Corporate Solutions at 888-349-1986 by February 29, 2016

I understand that the purpose of my health screening is to evaluate my health status and any potential health risks. I hereby request and authorize Wellness Corporate Solutions, LLC to transmit health information about me to the health management companies that provide services to my employer so that these companies may help me reduce, manage and/or control any such risks. I understand that Wellness Corporate Solutions, LLC is not responsible for diagnosing, treating, or preventing any medical disease or condition that I currently have or may have in the future. I also understand that Wellness Corporate Solutions, LLC will not give me medical advice and that I must seek such advice from my own physician. I understand that Wellness Corporate Solutions, LLC will not provide me any health information that identifies me. I acknowledge and agree that Wellness Corporate Solutions, LLC may provide my employer aggregate statistical health information which includes my health information. I understand that Wellness Corporate Solutions, LLC may also use my health information for its own internal business purposes such as to develop future wellness programs. Finally, I understand that I may faint, bruise, or have other effects as a result of my blood being drawn. I voluntarily agree and consent to participate in the health screening and accept and assume all risks associated with such participation. I hereby release and forever discharge Wellness Corporate Solutions, LLC, its owners, employees, and agents from any and all claims, demands, actions, and damages, including attorney’s fees and costs, arising out of or in any way related to my participation in the health screening.

PARTICIPANT INFORMATION (TO BE COMPLETED BY THE PARTICIPANT)

FIRST NAME

LAST NAME

DATE OF BIRTH (MM/DD/YYYY)

UNIQUE ID#

M     M             D     D             Y     Y     Y     Y

GENDER:  Male  Female

RELATIONSHIP:  Employee  Spouse/Dependant

PHONE NUMBER

HOME STREET ADDRESS

CITY  STATE  ZIP CODE

EMAIL ADDRESS

BODY MEASUREMENTS & BIOMETRIC RESULTS (TO BE COMPLETED & FAXED BY PHYSICIAN)

SCREENING DATE

FASTING STATUS:  Yes  No

M     M             D     D            Y     Y     Y     Y

HEIGHT (without shoes)  feet  inches

WEIGHT (without shoes)  Pounds

BMI  kg/m²

WAIST  Inches

BLOOD PRESSURE  mmHg

TOTAL CHOLESTEROL  mg/dL

HDL CHOLESTEROL  mg/dL

LDL CHOLESTEROL  mg/dL

TRIGLYCERIDES  mg/dL

GLUCOSE  mg/dL

NOTES:

ALL DATA MUST BE PROVIDED ABOVE USING PRE-DEFINED FIELDS. ATTACHMENTS WILL NOT BE REVIEWED OR PROCESSED.

PHYSICIAN SIGNATURE (REQUIRED)

PHONE NUMBER (Provider/Clinic)

PLEASE FAX COMPLETED DATA FORM TO: WELLNESS CORPORATE SOLUTIONS, SECURE FAX: 888-349-1986