



Physician Screening Form
STATE OF WISCONSIN

SECTION I: TO BE COMPLETED BY YOU (PLEASE PRINT)

Name: Employee ID #: Gender: M/F
Address:
City: State: Zip:
Work Phone Number: ( ) DOB:
Email:
Tobacco Use: ( ) Yes ( ) No

I, the undersigned understand that my employer is the Plan Sponsor of my Group Health Plan and may receive information regarding my participation in this health screening for administrative purposes, including but not limited to, billing and attendance. I understand that my Group Health Plan may be administered and/or insured by my Employer or an insurance company such as HealthPartners, one of these entities or their selected vendor may have access to my individually identifiable information for condition management purposes, or to appropriately operate or administer my Group Health Plan. The organizations involved in this activity recognize the importance of safeguarding individually identifiable health information and are obligated to take reasonable steps to protect such information.

Signature: Date:

SECTION II: TO BE COMPLETED BY YOUR PHYSICIAN

Examination and Blood Work Date:
Height: feet inches Weight: pounds Waist Circumference: inches
Total Cholesterol: mg/dl HDL: Ratio Total/HDL:
Glucose Level: mg/dl Triglycerides: LDL Cholesterol:
Blood Pressure: / mm/Hg A1c (optional):

Physician's Signature:
Physician's Name (please print):
Physician's Address:

Physicals and blood work must be completed between January 1, 2016 and December 28, 2016
Return this form by: e-mail (offsiteforms@interactivehealthinc.com) or fax (410-356-6205)

SUBMIT YOUR RESULTS on or before December 28, 2016
THIS FORM MUST BE COMPLETED TO RECEIVE YOUR REWARD

