

Health Care Provider Biometric Screening Form

INSTRUCTIONS

- **EMPLOYEE** - complete section 1
- **PROVIDER** - complete section 2 and 2a
- **EMPLOYEE WELLNESS HRA PARTICIPANT** - complete section 1, 2 and 2b

SECTION 1 - EMPLOYEE INFORMATION

Employee's Date of Birth (MM/DD/YYYY) / / Employee ID# Gender M F

Employee's First Name MI Employee's Last Name

Address Unit/Apt

City State Zip Code

Phone Number - -

Participant's Signature: _____

Date: / /
 (Month) (Day) (Year)

SECTION 2 - BODY MEASUREMENTS / BIOMETRICS RESULTS

Height <input type="text"/> ft <input type="text"/> in	Weight <input type="text"/> lbs	Glucose Fasting or Non-Fasting (circle one) <input type="text"/>	Blood Pressure <input type="text"/> Systolic <input type="text"/> Diastolic
Cholesterol Fasting or Non-Fasting (circle one) HDL: <input type="text"/> TRI: <input type="text"/> LDL: <input type="text"/> Total: <input type="text"/>		Date of Service/Test: _____ Results must be from July 1, 2011 or later to qualify	

SECTION 2a - FACILITY INFORMATION - for physician or office staff use

FOR HEALTH CARE PROVIDER: Samaritan Health Services is offering a voluntary wellness incentive program to encourage employees to understand their health risk. Please fill in all biometric values above, complete this section and fax to 425-918-5075.

Facility Name: _____

Health Care Provider's Name: _____

Phone Number: _____

Signature: _____

Date: _____

SECTION 2b - EMPLOYEE WELLNESS HRA OPTION

FOR SAMARITAN EMPLOYEE WELLNESS HRA PARTICIPANTS: Fill in all biometric values at the top of section 2 and provide corresponding lab report(s) from your Employee Wellness HRA behind this completed form and fax as indicated below.

Please fax completed form to **Vivacity at 425-918-5075**

Date Faxed: _____