PHYSICIAN SCREENING FORM – ATLANTIC PACKAGING

If you have received the health tests listed below from a health care provider on or after October 1, 2019, you may have the provider complete the bottom part of this form to receive credit in Atlantic Packaging's wellness program. Please scan and upload your completed form to https://atlanticpkgremote.uswellness.com/offsite on or before **August 31, 2020**. Receipt of your form will be confirmed within two business days to the email provided below (please print clearly and allow emails from uswellness.com).

STEP 1: To be completed by employee or spouse

First Name

Last Name

Street Address

City

State

Zip

Employee

Spouse

Date of Birth: (Month) (Date) (Year)

Gender: Female Male

( ) Phone Number

E-mail address *(to receive e-mail verification from US Wellness)*

STEP 2: To be completed by employee or spouse

I hereby authorize that individually identifiable health information supplied on this form may be released to and maintained by US Wellness, Inc., and Marathon Health for uses and disclosures permitted of covered entities under the federal HIPAA Privacy Rule and GINA. I hereby authorize that US Wellness may contact me about health and wellness matters related to this screening program.

X _____

Employee/Spouse Signature (SIGNATURE REQUIRED) Date

STEP 3: To be completed by physician office

PREGNANT ◯ **Yes** ◯ **No**

Cholesterol

Total Cholesterol

HDL Cholesterol

LDL Cholesterol

Triglycerides

Was patient fasting for more than 8 hours prior to this test? ◯ Yes ◯ No

Date of Test: (Month) (Day) (Year)

Glucose (Blood Sugar)

Was patient fasting for more than 8 hours prior to this test? ◯ Yes ◯ No

Date of Test: (Month) (Day) (Year)

Blood Pressure

Systolic /

Diastolic

Date of Test: (Month) (Day) (Year)

Waist Circumference

. inches

Date of Measurement: (Month) (Day) (Year)

Height:

(Feet) (Inches)

Weight (lbs):

Date of Measurement: (Month) (Day) (Year)

Health Care Provider Name Phone Number

Health Care Provider Signature Date

STEP 4: To be completed by employee (recommended) or physician office.

Scan and upload your completed form to https://atlanticpkgremote.uswellness.com/offsite on or before **August 31, 2020 at 11:59 PM EST.** Email confirmation will be sent to the email address provided above within two business days.

USWellness