PHYSICIAN SCREENING FORM – ROVER PETROLEUM

If you have received the health tests listed below from a health care provider on or after 10/1/2020, you may have the provider complete the bottom part of this form to receive credit in Rover Petroleum's wellness program. Please scan and upload your completed form to https://roverpetro.uswellness.com/ or fax to 240-477-1534 on or before 11/30/2021. Receipt of your application 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

First Name

Last Name

Street Address

City

State

Zip

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

Gender: Female Male

( ) Phone Number

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

STEP 2: CERTIFICATION OF TOBACCO USE: Tobacco use includes habitual use of chewing tobacco, cigarettes, cigars, pipes, E- cigarettes or E-cigars (electronic cigarettes and cigars) within the past 90 days. Please mark the appropriate box below:

☐ **Yes**, I have used tobacco products in the past 90 days

☐ **No**, I have not used tobacco products in the past 90 days

STEP 3: To be completed by employee

I understand that any individually identifiable health information about me obtained in the course of this screening may be released to and maintained by US Wellness. I understand that my information will not be shared with my employer. I authorize that US Wellness may contact me and that my information will be managed in accordance with the uses and disclosures permitted of covered entities under the federal HIPAA Privacy Rule. I may revoke this authorization through written communication to privacy@uswellness.com. Revocation of this consent will apply to data sharing that has not yet occurred at the time of the revocation

X _____

Employee Signature (SIGNATURE REQUIRED) Date

STEP 4: 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 Signature | Health Care Provider Name | Phone Number | Date

STEP 4: To be completed by employee (recommended) or physician office. Scan and upload your completed form to https://roverpetro.uswellness.com/ or fax to 240-477-1534 on or before **11/30/2021**. Email confirmation will be sent to the email address provided above within two business days.

USWellness