PHYSICIAN SCREENING FORM – KWIK TRIP

If you have received the health tests listed below from a health care provider on or after 10/01/2020 you may have the provider complete the bottom part of this form to receive credit in Kwik Trip's wellness program. Please fax your form to 240-477-1524 on or before 9/30/2021. A scan or picture of completed forms may also be uploaded at https://kwiktrip.uswellness.com. 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). **NOTE! It is highly recommended that you send your completed form to US Wellness directly. DO NOT rely on your physician's office to send it for you.**

STEP 1: To be completed by Coworker or spouse

First Name

Last Name

Street Address

City

State

Zip

( ) Phone Number

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

Coworker ID #

Coworker

Spouse

Gender: Female Male

E-mail address *(to receive e-mail verification that form was received by US Wellness)*

STEP 2: Both Coworker and on plan spouse must complete form separately (Signature Required)

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.
All sections must be completed for Coworkers and spouses to be eligible to receive credit for the wellness incentive.

X _____

Coworker/Spouse Signature (SIGNATURE REQUIRED) Date

STEP 3: To be completed by physician office

Note: The form needs to be completed in full for points to be awarded.

PREGNANT ◯ **Yes** ◯ **No (N/A)**

Date of Laboratory Testing: _____

Cholesterol

Total Cholesterol

HDL Cholesterol

LDL Cholesterol

Triglycerides

TC/HDL Ratio .

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

Glucose

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

Blood Pressure

Systolic /

Diastolic

Waist Circumference

. inches

Height:

(Feet) (Inches)

Weight (lbs):

X _____

Health Care Provider Name Health Care Provider Signature Phone Number Date

STEP 4: To be completed by Coworker or spouse

Fax completed form to 240-477-1524 on or before 9/30/2021 at 11:59pm CST. This form may also be uploaded via secure drop box at https://kwiktrip.uswellness.com. Email confirmation will be sent to email address provided above within two business days.

USWellness