BIOMETRIC SCREENING FORM– CITY OF PLANO

If you have received the health tests listed below with a health care provider on or after 9/1/2020, please have the provider complete the bottom part of this form to receive credit for the biometric screening only for the Connect4Health Premium Incentive Program. Please scan and upload your completed form to planotx.uswellness.com or fax to **301-337-3238** on or before 8/31/2021. Receipt of your form will be confirmed within two business days to the email provided below (please print clearly and remember to check your spam/junk folder, as the email will be from uswellness.com).

STEP 1: To be completed by employee or spouse/domestic partner

First Name

Last Name

Employee ID:

Employee Spouse Retiree

Gender: Female Male

( ) Phone Number

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

E-mail address *(An e-mail address must be entered in order to receive an e-mail verification of receipt of form from US Wellness)*

STEP 2: To be completed by employee/retiree or spouse/domestic partner

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

X

Employee/Retiree/Spouse/Domestic Partner 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 planotx.uswellness.com or **fax to 301-337-3238** on or before **8/31/2021**. Please note, if you choose to have your physician's office fax the screening form, follow up with your physician's office to ensure it has been sent. Email confirmation will be sent to the email address provided above within two business days of US Wellness' receipt of this form. Questions? Call (866) 926-6099 ext.955

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