2017 PHYSICIAN EXAM FORM
SMMC MEDICAL PLAN WELLNESS PROGRAM

SECTION 1 – PARTICIPANT INFORMATION – TO BE COMPLETED BY THE PARTICIPANT. **PRINT CLEARLY.**

FIRST NAME _____MI_____

LAST NAME _____

DATE OF BIRTH ____/____/_____ LAST 4 OF SS#_____ GENDER: □ MALE □ FEMALE

Employment Status □ Full time □Part-time Employee ID number _____

Home Address_____
City_____State _____Zip _____

Contact Phone Number (_____) _____-_____ E Mail Address _____

I voluntarily participate in the biometric screening for St. Mary's Employees enrolled in the St. Mary's medical plan.
My participation has no impact on my employment. I release St. Marys' Medical Center from all liability associated with any aspect of these services. I understand this screening may provide me with a better understanding of my health and lifestyle. This screening is only educational and not meant to diagnose illness or replace any health care. I will direct questions about illness or condition to my personal PCP. I authorize St. Mary's Medical Center to disclose my participation in the program to Highmark BCBS of WV for purposes of administering my reduction of my deductible in my St. Mary's Medical Plan. I authorize SMMC to disclose any elements of my personal information to Health Advocate program for purposes of education and /or to administer any incentive or benefits. My acceptance below confirms I read this form and agree to its terms. Except for unlawful uses of disclosure of my PHI, I release and hold harmless my employer and Highmark BCBS of WV from any liability that may arise from my participation in this biometric screening except for injuries arising from their respective gross negligence or willful misconduct.

_____Date _____/_____/_____
Participant's signature

HEALTH CARE PROVIDER – PLEASE COMPLETE THE FOLLOWING INFORMATION.
SECTION 2 - BODY MEASUREMENTS AND BIOMETRIC RESULTS - **TO BE SIGNED BY PCP ***

Height ____' ____"
Weight _____lbs.

Blood Pressure Systolic _____

Blood Pressure Diastolic _____

Total Cholesterol _____mg/dl
Triglycerides _____mg/dl
HDL _____mg/dl
LDL _____mg/dl

Glucose _____mg/dl
Hemoglobin AIC _____mg/dl

_____ _____
Primary Care Provider signature **Date**

*** IF YOU HAVE SEEN YOUR PCP AND SOME OF THESE TESTS WERE NOT PERFORMED, PLEASE CONTACT JAN KIRBY AT 304-526-1215 TO MAKE ARRANGEMENTS TO HAVE THE TESTS PERFORMED AT ST. MARY'S FOR FREE.**

ALL LAB TESTING MUST BE COMPLETED TO BE ELIGIBLE FOR THE WELLNESS PLAN

FAX COMPLETED FORM TO HEALTH ADVOCATE OFFICE 304-399-7469