

PROVIDER SCREENING FORM

PLEASE PRINT

Employer Name: _____

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____ City: _____

State: _____ ZIP Code: _____ Date of Birth: _____ Gender (circle) MALE FEMALE

Phone: _____ Email: _____

By signing this form, I know that:

1. I am consenting to participate in the voluntary employee wellness program.
2. My health information may be used and disclosed as described in the Equal Employment Opportunity Commission Notice Regarding Wellness Program (EEOC). I have been provided or have previously received a copy of the EEOC notice.
3. Penn Medicine, Lancaster General Health, Lancaster General Hospital, and any other groups associated with this wellness program, their affiliates, directors, officers, employees, successors and assigns, are released from any liability arising from or in any way connected with this program or the results derived therefrom.
4. I am responsible to pay any fees charged to me by my provider to have this form completed.
5. My health information may be used and disclosed as described in the Penn Medicine Lancaster General Health Notice of Privacy practices. A copy of this can be provided upon request.

Employee Signature _____

Date _____

This section is to be completed by a Health Care Provider or you may attach your test results.

HEIGHT Feet _____ Inches _____ BLOOD PRESSURE _____ / _____ TOTAL CHOLESTEROL _____

WEIGHT (lbs) _____ BLOOD GLUCOSE _____ HDL CHOLESTEROL _____

BMI _____ (FASTING) TRIGLYCERIDES _____ LDL CHOLESTEROL _____

WAIST CIRCUMFERENCE _____

I declare I have examined this individual and to the best of my knowledge, the results provided are true and correct.

Provider Signature _____

Exam Date _____

Provider Name (print) _____

Practice _____

RETURN THIS FORM BEFORE THE END OF THE WELLNESS PROGRAM ELIGIBILITY PERIOD

Email: LGHealthWellness@PennMedicine.upenn.edu

Secure Fax: 717.544.3504

Mail: Corporate Wellness | 1097 Commercial Avenue | PO Box 3555 | Lancaster, PA 17604-3555