Utility Keystone Trailer Sales

Physician Biometric Health Screening Form

INSTRUCTIONS

Participant – Complete Section 1
Health Care Provider – Complete Section 2
Participant – Send Completed Physician Form in sealed envelope to your Human Resource representative.

Section 1 – Participant Information – PRINT CLEARLY

Participant's First Name **MI** **Participant's Last Name**

_____

Participant's Date of Birth (MM/DD/YYYY) **Gender:** Male: _____

_____/_____/_____ Female: _____

Email Address: _____

Phone Number: _____

Please read the following disclosure statement. *I understand that my health screening data will be released to health plans associated with Utility Keystone Trailer Sales for the purpose of follow-up group health education.* ***My individually identifiable health information will not be shared with my Employer/UKTS; however, my Employer/UKTS may be advised of the fact of my participation in this health screening for purposes of qualification for incentives offered by my Employer/UKTS.*** *The importance of safeguarding individually identifiable health information is recognized and all organizations involved in this Biometric Health Screening are obligated to take reasonable steps to protect such information from unauthorized access or use. I understand it is my responsibility to 1) direct questions regarding testing to those administering the tests and 2) follow-up with my physician to discuss the results of these tests when so advised.*

Participant's Signature: _____**Date:**_____/_____/_____

Participant's Date of screening must be within 1/1/15 – 10/15/2015 *to receive completion credit.*

Section 2 – Body Measurements / Biometric Results – for healthcare provider or office staff to use only below this line.

FOR HEALTH CARE PROVIDER: Utility Keystone Trailer Sales is offering a voluntary wellness program to encourage participants to understand their health risks. ALL FIELDS ARE REQUIRED FOR THE FORM TO BE PROCESSED.

Height: _____ft. _____ in. **Weight:** _____lbs. **Blood Pressure:** _____/_____

Fasting status (please check one): _____Fasting _____ Non Fasting

Total Cholesterol: _____ **HDL:** _____ **LDL:** _____ **Glucose:** _____

Date of Tests must be between 1/1/15 – 10/15/2015 **Date of Service:** _____/_____/_____

Facility Name: _____**Phone Number:** _____

Health Care Provider's Name: _____

Provider's Signature: _____Date Completed: _____/_____/_____

PLEASE RETAIN A COPY FOR YOUR RECORDS.

SUBMIT COMPLETED FORM IN A SEALED ENVELOPE TO YOUR HUMAN RESOURCE REPRESENTATIVE.

PLEASE NOTE YOUR PERSONAL IDENTIFIABLE HEALTH INFORMATION WILL NOT BE SHARED WITH UTILITY KEYSTONE TRAILER SALES.