EMPLOYEE WELLNESS VERIFICATION FORM

EMPLOYEE IDENTIFYING INFORMATION (Must be Completed)

LAST NAME	FIRST NAME	M.I.:	**EMPLOYEE I.D. Number**
ADDRESS	CITY	STATE	ZIP CODE
Work Phone #	Cell or Home Phone #		

MEDICAL PROVIDER (Must Be Completed)

Doctor/Healthcare Provider Signature:	Telephone Number:
Address, City, Zip Code:	

I authorize my healthcare provider to release the information requested on this Health Goal Form to the ***Wellness Program Reviewer*** at ***Medical Analysis Clinic*** on behalf of City of Gulfport's Healthcare Plan, for the sole purpose of verifying my eligibility for the City of Gulfport's **Voluntary Health Contingent Based Health Premium Reduction Program**. This release will remain in effect for the **entire calendar year.** I understand that this release is a requirement of federal (HIPPA) and state privacy laws, and that my healthcare provider cannot require me to sign the authorization as a condition to providing me treatment. I understand that federal laws permit me to revoke this release at any time by notifying my healthcare provider in writing. I acknowledge that I will not be eligible to participate in the ***voluntary*** Health Contigent Based Health Premium Reduction Wellness Program through the City of Gulfport **if I do not provide this medical certification to the Wellness Program Reviewer at Medical Analysis Clinic**. My medical information **will not** be released to my employer.

Employee Signature:_____ Date_____

EMPLOYEES AND HEALTHCARE PROVIDER TO COMPLETE THIS SECTION

An alternative health standard for achieving this award is available to all participants because the standard for each participant is based on that person's medical condition. In response to any question, please do not include any genetic information, (i.e., family medical history and information related to genetic tests, genetic services, and genetic counseling or genetic diseases for which the employee may be at risk).

Employees who achieve targeted goals addressing health risks will receive a monthly premium reduction **(based on goal accomplishment).** This is a ***voluntary*** program to assist employees with improving their health. Employees are encouraged to discuss their health with their healthcare provider and develop a plan for improving targeted risks: tobacco usage, overweight, obesity, cholesterol stabilization, glucose stabilization, blood pressure stabilization, cancer screenings, alcohol/drug abuse, depression, stress, and other health risk identified at the time of this physical exam/consultation.

Weight	Height	BMI	Waist Circumference	Weight and Waist Goal
Blood Pressure	Blood Pressure Goal		Fasting Glucose	Glucose Level Goal
Total Cholesterol	HDL		LDL	Triglycerides
l Lipid Levels Goal	Well Woman Exam: Yes ❒ No ❒			Well Man Exam: Yes ❒ No ❒

Medical Provider Signature:_____ Date:_____

Hearing/Eye Exam Yes ❒ No ❒	Nutritional Counseling Yes ❒ No ❒	Bone Density Yes ❒ No ❒
Depression/Stress Management Yes ❒ No ❒	Weight Loss Counseling Yes ❒ No ❒	Obesity Counseling Yes ❒ No ❒
Referral to Tobacco Cessation Class Yes ❒ No ❒	Referral to Diabetes/Cardiac Class Yes ❒ No ❒	
Referral to Healthy Lifestyle class Yes ❒ No ❒	Other:	

Identified Health Risks	**Health Goals and Referrals**

FORM CAN BE FAXED TO MEDICAL ANALYSIS AT 228-863-6762