Physician Screening Form

American Access Casualty Company

SECTION I: ***TO BE COMPLETED BY YOU*** **(PLEASE PRINT)**

Name: _____ Employee ID #: _____ Gender: M / F

Address: _____

City: _____ State: _____ Zip: _____

Work Phone Number: ( ) _____ DOB:_____

Email: _____

I, the undersigned understand that my employer is the Plan Sponsor of my Group Health Plan and may receive a list of my participation for administrative purposes, including but not limited to, billing and attendance. I understand that my Group Health Plan may be administered and/or insured by my Employer or an insurance company such as BCBS, one of these entities or their selected vendor may have access to my individually identifiable information for condition management purposes, or to appropriately operate or administer my Group Health Plan. The organizations involved in this wellness activity recognize the importance of safeguarding individually identifiable health information and are obligated to take reasonable steps to protect such information.

Signature: _____ Date: _____

SECTION II: ***TO BE COMPLETED BY YOUR PHYSICIAN***

Examination and Blood Work Date: _____

Height: _____feet _____inches Weight: _____pounds Waist Circumference: _____inches

Total Cholesterol: _____mg/dl HDL: _____ Ratio Total/HDL: _____

Glucose Level: _____ mg/dl Triglycerides: _____ LDL Cholesterol: _____

Blood Pressure: _____ / _____ mm/Hg

Physician's Signature: _____

Physician's Name (please print): _____

Physician's Address: _____

_____

Physicals and blood work must be completed between ***May 1, 2016*** *and* ***February 28, 2017*** *for physician form credit. Return this form by*: ***e-mail (offsiteforms@interactivehealthinc.com), fax (410-356-6205) or mail (Interactive Health, Attn: Alternative Means, 11409 Cronhill Drive, Suite M, Owings Mills, MD 21117****).*

PLEASE PICK ONE METHOD FOR SUBMITTING YOUR RESULTS by February 28, 2017.

THIS FORM MUST BE COMPLETED IN ITS ENTIRETY TO RECEIVE YOUR INCENTIVE CREDIT.