ICWS Integrated Corporate Wellness Solutions

FINDLAY CITY SCHOOLS

BIOMETRIC SCREENING PHYSICIAN FORM

TO PARTICIPANT: Findlay City School employees are eligible for a $300 incentive for submission of the physician biometric screening form. When scheduling your appointment with an in network UMR provider, request an Annual preventive Physical. If the provider should bill for anything additional other than a wellness visit, you will be responsible for any out of pocket expenses. www.umr.com

ICWS must receive values for the applicable test parameters listed at the bottom of this page in order to complete your Biometric Screening. Please complete the following contact information and follow the directions provided below. All programs are confidential and HIPAA compliant. Any information shared with the ICWS team will not be disclosed except in accordance with HIPAA laws.

PARTICIPANT NAME: _____

PARTICIPANT PHONE NUMBER: _____

PARTICIPANT EMAIL ADDRESS: _____

PARTICIPANT DATE OF BIRTH: _____

TOBACCO/NICOTINE USE: Y / N (circle one)

****IMPORTANT NOTES*****

- You may submit blood/screening tests completed by your health care provider between 7/1/2022 and 6/30/2023
- Form must be completed and returned to ICWS no later than the **July 7, 2023 deadline** to receive credit
- Return form to support@icws-wellness.com or via secure fax at (855) 270-6189
- Results must be written on this form and your health care provider information must be completed below
- By signing below, you authorize your medical provider to release the biometric screening information to ICWS

PARTICIPANT SIGNATURE: _____DATE: _____

TO PROVIDER: The health management program offered through ICWS is not intended to treat, diagnose or replace physician involvement, but rather to create and promote an atmosphere of healthy living and learning through the implementation of wellness initiatives. For more information, please contact support@icws-wellness.com.

PROVIDER NAME _____ CLINIC: PHONE #: (_____)

ADDRESS: CITY: STATE:_____

PROVIDER / CLINIC SIGNATURE:_____

LAB & SCREENING TEST DATE: _____/_____/_____ NPI # _____

TEST PARAMETER	VALUE	UNITS
Total Cholesterol		mg/dL
HDL Cholesterol		mg/dL
LDL Cholesterol		mg/dL
Triglycerides		mg/dL
Glucose		mg/dL
Systolic Blood Pressure (rest)		mmHg
Diastolic Blood Pressure (rest)		mmHg
Height		ft/in
Weight		lbs
Waist Circumference		in
FASTING: YES / NO		