Biometric Verification Form

This confidential form will be used to help improve your overall health. Please fully complete this form as part of your employer's wellness program. You must obtain your results and submit them no later than **October 31, 2025**.

SECTION 1: PERSONAL INFORMATION

Participant Name: _____

Employee ☐ Spouse ☐ If spouse, list employee name: _____

Employer: _____ Phone Number (___) _____-_____

E-mail: _____

SECTION 2: VITALS AND LABS

Date of Screening M M - D D - Y Y

Tobacco Use ☐ YES ☐ NO

Metabolic Syndrome Guidelines

1. Waist Circumference	**Men:** Less than 40 Inches **Women:** Less than 35 Inches
2. Total Cholesterol	Less than 200 mg/dL
3. Triglycerides	Less than 200 mg/dL
4. Blood Pressure	**Systolic:** Less than 140 mmHg **Diastolic:** Less than 90 mmHg
5. Fasting Glucose	Less than 100 mg/dL
6. BMI	Less than 30.

Waist Measurement	☐☐.☐ in
Total Cholesterol	☐☐☐ mg/dL
Triglycerides	☐☐☐ mg/dL
Blood Pressure	☐☐☐/☐☐☐ mmHg
Glucose	☐☐☐
BMI	☐☐

Instructions for Primary Care Physicians:

- Discuss all values with your patient. along with tobacco use.
- Once the form is completed and signed, please return to patient for submission.

Accepting preventive care visits between: **11/1/24 - 10/31/25**

Provider Stamp or Signature:

I hereby acknowledge that the undersigned patient is up-to-date with recommended preventive care including, but not limited to, glucose; BMI; blood lipids; breast, cervical, and colon cancer screenings; general health risk status and screenings as age, gender, and family/medical history appropriate.

Provider Name: _____ Provider Signature: _____

Date: _____ Phone Number: (___)_____-_____

Consent to Process:

I hereby certify that the information on this form is accurate to the best of my knowledge and I authorize this data to be provided to Britton Gallagher for the purpose of administering my/my spouse's employer sponsored wellness program.

I authorize my/my spouse's employer, Britton Gallagher and our sub-contracted vendors, and/or other partners engaged by my/my spouse's employer health plan to conduct services in connection with my/my spouse's employer wellness program ("Program"). My participation in this initiative and the Program is voluntary.

I authorize the use and disclosure of health and personal information about me for purposes of my participation in the Program. I understand my employer may determine my health plan payroll contributions, incentives and/or rewards based on: a. my participation in the program; and/or b. the results of my biometric measures. This information may also be used to determine appropriate health education and health outreach. This Program is not a diagnostic tool; it does not provide, nor is it a substitute for, professional medical advice, diagnosis or treatment. The information provided by the Program is for educational purposes only and should not be interpreted as a diagnosis or as a recommendation for a specific treatment plan, product, or course of action. This authorization will expire 12 months from the date of my new medical plan year or one year from date of this document, whichever is later. Refer to your employer for more information to determine the impact on your health plan payroll contributions, incentives and/or rewards.

Participant Signature: _____ Date: _____

Submit Fully Completed Form to: Nurse Stephanie

NOTE: You are responsible for submitting this fully completed form for processing by the due date above.
Illegible forms will not be processed and all information must be submitted to receive credit.