“Client” Program
2020 Biometric Screening Form

EMPLOYEE
Please fill out the top portion of this form and take it to your medical provider when you complete your biometric health screening. The provider-based screening **must** occur between [insert date] and [insert date] to count towards the 2020 “client” program activities. Once completed by your provider, it is YOUR responsibility to return this form to (see contact information and instructions below).

TODAY’S DATE ____/____/____

PATIENT NAME (PLEASE PRINT CLEARLY)

DATE OF BIRTH ____/__/____

EMPLOYEE NUMBER

MEDICAL PROVIDER
Your patient has an opportunity to complete a biometric screening as a part of a wellness incentive program. Please review the components to be included in the screening. When the screening is complete, please fill out this form, sign and date it and return it to the patient. Please fill out this form completely.

Provider: Please complete this section

ANNUAL HEALTH SCREENING CRITERIA	RESULTS
FASTING	○ Yes ○ No
TOBACCO USER	○ Yes ○ No
BODY MASS INDEX (BMI)	Height ____“ / Weight ____ ____ ___ BMI ____ ____ . __
WAIST CIRCUMFERENCE	Value: __ ___ “
BLOOD PRESSURE	Value: ____ ____ ____ / ____ ____ ____
TOTAL CHOLESTEROL	Value: ____ ____ __
HDL CHOLESTEROL	Value: ____ ____ __
TRIGLYCERIDES	Value: ____ ____ __
LDL CHOLESTEROL	Value: ____ ____ __
TOTAL CHOLESTEROL TO HDL RATIO	Value: ____ . ___
BLOOD SUGAR	Value: ____ ____ __

Date Tests Administered:

PROVIDER SIGNATURE

PLEASE PRINT (OR PROVIDER STAMP)

PROVIDER PHONE NUMBER

***** RETURN TO YOUR MARATHON HEALTH COACH*****

OR

FAX YOUR COMPLETED FORM TO 910-377-3419

Marathon health For life.