Alternative Physician Form

This form must be completed and signed by you and your physician/screening provider in order to substitute for the **Biometric Screenings – Neenah Joint School District.**

Participant's Name: _____Date of Birth:_____

(If spouse indicate employee's name here): _____

Participant's Address: _____

Participant's City _____ State _____ Zip _____

Participant's Phone Number: _____ Gender: Male Female (circle one)

Physician's/Screening Provider's Name:

_____

Name of Practice or Clinic: _____

Practice or Clinic Phone Number: _____ Date of Visit: _____

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This section to be completed by Physician's office/Screening Provider.

Triglycerides: _____ Total Cholesterol: _____

HDL Cholesterol: _____ LDL Cholesterol: _____

Total Cholesterol/HDL Cholesterol Ratio: _____

Glucose:_____ Blood Pressure:_____

Height: _____ Weight:_____ Waist Measurement:_____

BMI: _____Nicotine Use (response)_____

Physician/Screener signature:_____ Date:_____

Participant signature : _____ Date: _____

Attention participant :

- For confidentiality purposes, this form should be mailed, faxed or emailed to:

Prevea Health
Attn: Brittany Ingledew
737 Cormier Rd
Green Bay WI 54304
Fax: 920-431-1994
Email: healthandwellness@prevea.com