Physician Screening Form
Federal Signal Wellness

SECTION 1 REQUIRED: ***To be completed by you (Please print clearly)*** **Business Unit: Elgin Sweeper**

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

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **DOB:** _____ **Last 4 digits of SSN:** _____

Email: _____

Are you the employee or the spouse? (Please circle one): Employee Spouse

Do you use tobacco in any form? (Please circle one): Do not use tobacco Use tobacco

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 Health Care Professional (HCP) conducting the examination:***

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**

HCP's Signature: _____

HCP's Name (please print): _____

HCP's Address: _____

_____

Physicals and blood work must be completed by **December 1, 2023** for physician form credit.

Return this form to: AMG-AAWCallCenter@aah.org; or via **fax** at: **847-698-4486**

THIS FORM & THE BACK SIDE MUST BE COMPLETED IN ITS ENTIRETY TO RECEIVE YOUR WELLNESS INCENTIVE CREDIT.

Revised 5/2023

Advocate Health Care
Now part of ADVOCATEHEALTH

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION - Federal Signal

1) Participant Information: _____
Name of Participant (please print)

_____ (_____) _____
Date of Birth Area Code / Telephone Number

_____ _____
Address City/State/Zip

2) Persons/Organizations Authorized to *Disclose* Participant's Health Information:

Advocate Health Care - Wellness Services
3075 Highland Parkway
Suite: 600
Downers Grove, IL 60515

3) Persons/Organizations Authorized to *Receive* Participant's Health Information:

Federal Signal

4) Health Information to be Disclosed and Purpose of Disclosure:

- My participation/completion of my health biometric screening to Federal Signal for the purpose of administering the wellness program incentive benefits.

5) Expiration Date: This Authorization will expire one (1) year from the date signed.

6) YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Inspect or Copy: I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this Authorization.
Right to Receive Copy of Authorization: I understand that if I agree to sign this Authorization, which I am not required to do, I will be provided with a signed copy of this Authorization.
Right to Refuse to Sign Authorization: I understand that this Authorization is voluntary and that I may refuse to sign this Authorization. Unless allowed by law, my refusal to sign this Authorization will not affect my ability to obtain treatment from Aurora Health Care. ***However, I also understand that the wellness/ health services that I receive from Aurora are provided for the purpose of disclosing to the persons/organizations indicated above for the reasons indicated above. Refusal to sign this Authorization may result in a refusal by Aurora to provide me with the specific wellness health services that have been requested.***
Right to Revoke Authorization: I understand that written notification must be presented to the Medical Records Department to cancel this Authorization. I understand that my withdrawal will not be effective as to uses and/or disclosures of health information already made in reliance on this Authorization.
Redisclosure Notice: I understand that if the person(s)/organization(s) listed above are not governed by Federal privacy laws, the health information disclosed as a result of this Authorization may be redisclosed by the recipient and no longer be protected by such laws.

I have had an opportunity to review and understand the content of this Authorization. By signing this Authorization, I am confirming that it accurately reflects my wishes.

7) Signature of Participant: _____ Date: _____

Signature of Parent/Legal Guardian: _____ Date: _____
(If under age 18)