MAKE A CHANGE
make a difference
YOUR HEALTH. YOUR WEALTH. YOUR LIFE.

Dear Health Care Provider,
Your patient is participating in a wellness initiative sponsored by the Huron-Erie School Employees Insurance Association. As part of the employee wellness initiative, we are asking a licensed health care professional (MD, DO, NP, PA) to complete the clinical measurement and provider information below. We appreciate your assistance in completing this form. Thank you for supporting your patient's personal wellness plan.

COMPLETION DIRECTIONS

1. **Take this form to your Physician and ask them to complete the PROVIDER INFORMATION sections.**
2. **Provide the section below the dotted line to your Treasurer as proof of completion. This will lower your medical plan deductible.**

----------KEEP THIS SECTION FOR YOUR PERSONAL RECORDS----------

PERSONAL INFORMATION – (TO BE COMPLETED BY *PATIENT*)

Date of Appointment:_____(Wellness Exam must have been conducted Annually)

First Name:_____MI:_____Last Name: _____

Gender:_____Date of Birth:_____Phone:_____Address:__

_____

CLINICAL MEASUREMENT- (TO BE COMPLETED BY *PHYSICIAN*)

Height ____ft_____in

Weight _____(lbs)

Blood pressure – Systolic (high #) _____

– Diastolic (low #) _____

Total cholesterol level _____(mg/dL)

HDL cholesterol level _____(mg/dL)

LDL cholesterol level _____(mg/dL)

Triglyceride level _____(mg/dL)

Glucose level _____(mg/dL)

✂----------**CUT HERE**----------

Submit this section to your,Treasurer, to receive a lower deductible medical plan.

PROVIDER INFORMATION- TO BE COMPLETED BY PHYSICIAN

Physician Name (Print):_____Phone: _____

Office Address: _____

Physician Signature:_____Date:_____

AUTHORIZATION:

Patient Signature:_____Date: _____

Print Patient's Name:_____