

**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 Health Assessment Completion Page AND the section below the dotted line ONLY to the Treasurer as proof of completion.  
Employees that complete a health screening by Nov. 1, 2024 will remain in the lower deductible plan (\$500). Those that do not complete the health screening will be placed in the higher deductible plan (\$750) effective Jan. 1, 2025.

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

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

Date of Appointment: \_\_\_\_\_ (Exam must have been conducted by 11/01/24)

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_

Gender: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

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

Height \_\_\_\_\_ ft \_\_\_\_\_ in Blood pressure – Systolic (high #) \_\_\_\_\_

Weight \_\_\_\_\_ (lbs) – Diastolic (low #) \_\_\_\_\_

Total cholesterol level \_\_\_\_\_ (mg/dL) Triglyceride level \_\_\_\_\_ (mg/dL)

HDL cholesterol level \_\_\_\_\_ (mg/dL) Glucose level \_\_\_\_\_ (mg/dL)

LDL cholesterol level \_\_\_\_\_ (mg/dL)

✂-----CUT HERE-----✂

*Submit this section along with verification of your completed health assessment to your Treasurer in order to remain in the lower deductible plan.*

**PROVIDER INFORMATION- TO BE COMPLETED BY PHYSICIAN**

Physician Name (Print): \_\_\_\_\_ Phone: \_\_\_\_\_

Office Address: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**AUTHORIZATION:**

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_