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, 2025 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, 2026.**

----------**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: _____