WEBER STATE UNIVERSITY
Employee Wellness

DIVISION OF HUMAN RESOURCES
3992 CENTRAL CAMPUS DR DEPT. 3501
OGDEN, UTAH 84408
PHONE: (801)626-6474
EMAIL: WELLNESS@WEBER.EDU

BONUS PROGRAM
PHYSICIANS OPTION FORM

PLEASE RETURN FORM TO:
WILDCAT CENTER (WI) ROOM #210F
FAX: (801)626-6685

Please have your provider complete this form to report the values of your biometric screening (blood pressure, height, weight, BMI, fasting glucose and lipid Panel [total cholesterol, HDL cholesterol]).

PARTICIPANT INFORMATION

Name (please print):	Birthdate:	Email Address:	Today's Date:
☐ I am a spouse of a Weber State Employee	Employee Name (Please Print):		

HEALTH GUIDELINES

No tobacco or nicotine use of any kind
BMI: <25 OR BF ≤ 22% for men
Fasting total cholesterol: ≤200
Fasting blood glucose: ≤100
BMI: <25 OR BF ≤ 32% for women
HDL cholesterol: ≥45
Blood Pressure: ≤120/80

BIOMETRIC RESULTS-This section to be completed by a medical provider

Height	Weight	BMI	Total Cholesterol	HDL	Blood Glucose	Blood Pressure

PHYSICIAN NOTES: **Must be completed!**

Tobacco/Nicotine	BMI/ Body Fat	Fasting Cholesterol	HDL Cholesterol	Fasting Glucose	Blood Pressure
☐ Not using	☐ Meets guidelines	☐ Meets guidelines	☐ Meets guidelines	☐ Meets guidelines	☐ Meets guidelines
☐ Medication	☐ Medication	☐ Medication	☐ Medication	☐ Medication	☐ Medication
	☐ Lifestyle Change	☐ Lifestyle Change	☐ Lifestyle Change	☐ Lifestyle Change	☐ Lifestyle Change
	☐ Ranges are considered normal	☐ Ranges are considered normal	☐ Ranges are considered normal	☐ Ranges are considered normal	Ranges are considered normal

Additional Comments:

PHYSICIAN'S INFORMATION

Physician's Name:	Physician's Signature:	Date:

Consent information: This information, along with any personal health information provided in completing the health assessment, is maintained in a secure area within the Employee Wellness Office to be used only in conjunction with the Wellness Program and for calculating this incentive. It is not shared with your supervisor or Weber State University's Human Resources Department. Employee Wellness will only notify the Payroll Office that the requirements have been met to receive the Bonus. By submitting this form, I hereby consent to use my biometric screening information for the purposes specified above, and grant any wellness program employee permission to contact me regarding my results. You may revoke your authorization of the Employee Wellness Office to use this information at any time by notifying wellness@weber.edu. This consent will remain valid until so notified.

Office use only!	Date Received	Date Recorded	Recorder Initials	Met _____ out of 6 criteria

Weber State University Wellness Pays Bonus Program Informed Consent

Purpose

The primary purpose of the Wellness Pays Bonus program is to identify individual health risks based upon the responses to the Wellsource PWP questionnaire and the results of a blood lipid evaluation.

By signing this form, I desire to participate in this program and willingly give my consent for evaluation of my present level of health. I further give permission for those health tests I've opted to take, that may include one or all of the following: blood, body composition, and other screening tests. I accept the responsibility of taking any appropriate actions indicated as a result of health problems or high-risk indicators identified during testing. I understand that my participation is voluntary, and that I may withdraw or discontinue my participation at any time without penalty or prejudice. I further release Weber State University and the Department of Human Recourses from any health problems that may occur as a result of my participation.

Limitations

My blood lipids and glucose will be measured using the Cholestech LDX blood lipid profile machine. This device, while not guaranteed to have 100% accuracy, has meet the precision and accuracy guidelines set by the National Cholesterol Education Program.

I understand that the Employee Wellness staff and interns are not a medical physicians and do not dispense medical advice, nor diagnose or treat any medical condition.

Benefits to be expected

Participation in a wellness program has been associated with beneficial changes in health, fitness, nutrition, attitude and safety including increases in muscular strength, endurance, cardio-respiratory endurance and improvements in body composition.

Confidentiality

All records collected will remain in the Employee Wellness office in a locked file cabinet. Access to the records is limited to the staff of the Wellness program that has the duty of processing the records.

Data is generated electronically by use of a computer. Access to the electronic records is limited to the staff of the Wellness program that has the duty of processing the records.

Contact Persons

Questions related to the Wellness program or about accommodations may be directed to Raeanna Johnson, Employee Wellness Supervisor, ext. 6480.

☐ I certify that I am not a tobacco user, and do no use tobacco in any manner including smoking, vaping and chewing.

☐ I would like to be notified of health improvement programs if the results from my assessment indicated that I may be at increased risk for developing future health problems.

I understand that by signing my name below, I have given my consent and release as described above.

Participant Printed Name Signature W# Date

Office Witness Signature Date