MERCYONE

# Physician Form
## Have your Health Care Provider complete and sign the form below

First Name _____ Last Name _____

Employer County_____ Home Address _____

City _____ State _____ Zip _____ Date of Birth _____

Gender_____ Email address: _____

The information you are submitting may be shared in aggregate form with your company for the sole purpose of administering wellness programming services or to conduct other wellness activities as permitted by law. MercyOne Business Solutions will maintain the confidentiality of your personally identifiable information and will only release personal information as permitted by law for the sole purpose of wellness program administration. At no time will your Personal Health Information (PHI) be shared with your company or an agent of your company. I authorize my data to be uploaded for incentive purposes.

**Participant Signature**: _____

**Each item below should be filled out by your health care provider**

Fasting: Yes No

Blood Pressure: _____

Height: _____ Weight: _____ Waist Circumference: _____

Total Cholesterol: _____ HDL: _____ LDL: _____

Triglycerides: _____ Glucose: _____

_____ _____

**Health Care Provider Signature** **Date**

**Submit one of two ways:**
**Fax: 515-358-9294**
**Scan to: corporatehealth@mercydesmoines.org**

ISAC
Iowa State Association of Counties