Health Provider Screening Form

COMPLETION DIRECTIONS

1. Please read the instructions and complete ALL fields like this: PRINT CLEARLY x
2. The provider must complete and sign the form.
3. Make sure the form is submitted via fax at 866.877.7095 or uploaded to https://boyd.adurolife.com/submission.
4. Questions? Visit https://help.adurolife.com.

EMPLOYEE

First Name | Middle | Employee ID

Last Name | Date of Birth (M M / D D / Y Y Y Y)

Gender

☐ Male ☐ Female

I understand that my personally identifiable health information will be kept confidential and will not be given to my employer. I acknowledge that my biometric data may be transferred between vendors authorized by my Wellness Program for the purposes of aggregated data analysis, evaluation for participation in specific Wellness program offerings, and/or transferred to another health services provider as directed by my Wellness Program for the purposes of administering or managing my Wellness program all as permitted by law. I authorize the disclosure of my biometric data for evaluation for participation in specific Wellness program offerings even if an authorized vendor may receive a financial benefit from making the disclosure.
I understand that Information will only be transmitted through secure channels secured with appropriate safeguards to the extent permitted by and in accordance with the requirements of applicable laws. I also authorized the upload of my biometric data to my online Wellness profile. I do not authorize my employer to see my personal biometric data.

Signature _____ Date _____ Printed Name _____

*** FOR PHYSICIAN OR OFFICE STAFF USE ONLY BELOW THIS LINE ***

BODY MEASUREMENTS

Height (FT IN) | Weight (LBS) | Waist (IN) | Fasting ☐ Yes ☐ No | Date Ordered (M M / D D / 2 0 Y Y)

Blood Pressure Systolic	Blood Pressure Diastolic	HDL Cholesterol (mg/dL)	Total Cholesterol (mg/dL)	LDL Cholesterol (mg/dL)	Triglycerides (mg/dL)	Glucose (mg/dL)

PROVIDER INFORMATION

DO NOT USE STAMP - FACILITY AND AGENT NAME MUST BE PRINTED IN THESE BOXES

Facility Name

Certifying Agent First Name

Certifying Agent Last Name

NPI #

☐ REQUIRED: I certify these values are correct

Signature _____ Date (M M / D D / Y Y)

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