2020 Provider Qualification Form

Please return completed form to Ulliance.
Incomplete forms will not be accepted.

Participant Instructions: Complete, in full, this part of the form and take it to your health care provider to complete. Biometric screening results must be within one year of today's date. **Obtain a copy of this completed form for your records and to use when completing the online Health Risk Assessment (HRA). Submit this form to Ulliance by Fax: 248-680-2103 or Email: chasselbring@ulliance.com. Last day to enroll September 5, 2020.**

Employer: **Wayne State University**

Last Name	**First Name**
Banner or Access ID	**Gender** ☐ Male ☐ Female
Primary Phone Number	**Date of Birth**

By signing below, I consent to the participation in the Wellness Warriors program, associated screenings, and to the release of my medical information to Ulliance. I understand that my participation is voluntary and my employer *will not* receive my results.

Signature	**E-Mail Address**

Provider Instructions: Please make sure that all sections below are completed in full.

- If using results from a previous physical, they must be from 10-21-2019 through 9-5-2020.
- ***Sign and return the form to: Fax: 248-680-2103 or Email: chasselbring@ulliance.com***

		Ulliance Use Only	
Date of Exam:	**Fasting Status:** ☐ **Yes** ☐ **No**		
BIOMETRIC SCREENING TARGETS	**BIOMETRIC SCREENING RESULTS**		
Nicotine Use Target: Never used or quit > 6 months	**Nicotine Use** ☐ **No, non-user** ☐ **Yes, user**	☐ Risk	☐ No Risk
Body Mass Index Target: BMI <25	**Height** _____ **in** **Weight** _____ **lbs** **BMI** _____ **Waist Circumference** _____ **in**	☐ Risk	☐ No Risk
Blood Pressure Target: <120/80; both numbers	**BP** _____ **/** _____ **Pulse** _____	☐ Risk	☐ No Risk
Total Cholesterol Target: <200	**Total Cholesterol** _____ **LDL** _____ **TRG** _____ **HDL** _____ **TC/HDL Ratio** _____	☐ Risk	☐ No Risk
Blood Sugar (Glucose) Target Fasting: <100 Target Non-fasting: ≤139	**Blood Sugar** _____	☐ Risk	☐ No Risk
Other/Comments:		**# of Health Targets Met:** _____	

Provider Signature: By signing below, I verify the information above is complete and accurate.

Provider Printed Name	**Tax ID**
Provider Signature **Date**	**Provider Phone Number**

Please return to Ulliance:

Email: chasselbring@ulliance.com **Fax:** 248-680-2103 **Mail:** 900 Tower Dr., Suite 600, Troy, MI 48098