2019 Ozaukee County **Biometric Form**

Employee/Spouse

Employee/Spouse

Please fill out the top portion of this form and take it to your medical provider when you go for your health screening. Once completed by your provider, it is YOUR responsibility to return this for to Human Resources (see contact information and instructions below). Please allow 14 business days for processing.

Patient Name (Please Print) | Date of Birth | Patient Phone Number

	___ /___ /___	

Ozaukee County: Employee ___ Spouse ___

If the Patient Listed is a Spouse: Employee Name | Employee Date of Birth

	___ /___ /___

Ozaukee County Employee/Spouse

DELIVER OR MAIL YOUR COMPLETED FORM TO THE ADDRESS BELOW.

Human Resources
Attn: Ellen Jarr
121 W Main St.
Port Washington, WI 53074

Medical Provider

Medical Provider

Your patient has the opportunity to complete a biometric screening as part of a health plan incentive program. Please review the components to be included in the screening. When the screening is complete, please fill out this form, sign and date it, and return it to the patient. Please fill out this form completely; missing data will result in this form being rejected.

ANNUAL HEALTH SCREENING CRITERIA	RESULTS
FASTING	YES ☐ NO ☐
BODY MASS INDEX (BMI) < 30	PASS ☐ FAIL ☐
BLOOD PRESSURE <130/90	PASS ☐ FAIL ☐
TOTAL CHOLESTEROL <200	PASS ☐ FAIL ☐
BLOOD GLUCOSE (FASTING BLOOD SUGAR) <100	PASS ☐ FAIL ☐

Provider Signature | Provider Phone Number

Please Print (or Provider Stamp) | Date Tests Administered ___ / ___ / ___