EACS 2026 Wellness Incentive Program

HEALTHCARE PROVIDER VERIFICATION FORM

Instructions: Complete all fields of this form and submit with the required biometrics information (height, weight, waist circumference and blood pressure) as well as blood work (total cholesterol, LDL cholesterol, HDL cholesterol, triglycerides, and hemoglobin A1C). All of the requirements listed above are **REQUIRED** for your submission. If any value is missing, you will be asked to resubmit with all information provided.

Submit this documentation to ParkviewWorkplaceWellness@parkview.com by December 31, 2026.

To be filled out by the Participant:

Participant Name: _____ **EMPLOYEE ID #:**_____

Gender: Male: _____ **Female:** _____ **Work Location:** _____

Date of Birth: _____ **Email:** _____

Authorization to Release Medical Information

I do herby authorize the release of the following personal health information to Parkview Workplace Wellness for the purpose of confirming eligibility to receive my wellness incentive.

Signature: _____ **Date:** _____

Your PHI (personal health information) is protected under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), and will be kept secure by Parkview Workplace Wellness. Parkview Workplace Wellness will notify your employer when you have completed this component satisfactorily. Your employer will not have access to your legally protected health information. Parkview Workplace Wellness will act as the confidential record keeper of the Health & Wellness Incentive Program on behalf of your employer.

To be filled out by the Physician or Healthcare Provider:

Date participant underwent his/her Physical Exam: _____

Height: _____
Weight (lb): _____
Blood Pressure: _____
Waist Circumference (in): _____

Total Cholesterol: _____
LDL: _____
HDL: _____
Triglycerides: _____
Hemoglobin A1C: _____

Physician/Healthcare Provider Signature: _____

To be completed by Parkview Staff: Date

Received: _____

Date Entered into Tracker: _____