Biometric Screening / Annual Physical Form

City of Richardson

EMPLOYEE INFORMATION (Please Print)

______________________ ______________________ ____ _____/_____/__________

Last Name First Name MI DOB (MM/DD/YYYY)

______________________ (_____) _____-_______

Employee ID Employee Phone Employee Signature: ___________________________________

ANNUAL PHYSICAL VALIDATION

To verify the completion of an **ANNUAL PHYSICAL**, please fill in the information below, and then have a representative from your physician's office sign and date the form. The form must be faxed to Methodist Health System at **214-947-6594** or emailed to **LiveBright@mhd.com** by **September 30, 2019**. Your individual personal health information is and will not be shared with your employer or benefits provider.

_________________________ (________)________-__________ (________)________-___________

Physician Name Physician Phone Physician Fax

Physician Signature: ________________________________ Date of Physical: _________________

BIOMETRIC SCREENING VALIDATION TO BE COMPLETED BY PHYSICIAN

To verify the completion of a **BIOMETRIC SCREENING**, please have a representative from your physician's office sign and complete the form below. You are responsible for the cost of any screening tests as well as any additional charges incurred during the physician's visit. You or your physician may submit a claim to your medical insurance carrier if coverage is available to you.

	Your Value	Recommended Range	High Risk Range
Total Cholesterol	____	<200	≥240
HDL Cholesterol	____	>59	<40 M, <50 F
LDL Cholesterol	____	<130	≥160
Risk Ratio (TC/HDL)	____	≤4.5	≥6.0
Triglycerides	____	<150	≥200
Fasting Glucose	____	<100	≥126
Waist Circumference (in.)	____	15-35in F, 15-40in M	>35 F, >40 M
Blood Pressure	____	<120 / <80	≥140 / ≥90
Height (in.)	____		
Weight (lbs.)	____		

I certify that I have completed for this patient the tests listed above. Furthermore, I certify that this form has been completed by a member of my staff.

_____________________________ _____________________________ ___/___/______

Physician Name (Please Print) Physician Signature MM / DD / YYYY