Biometric Screening Form

SECTION 1 - PARTICIPANT INFORMATION

Participant's Date of Birth (MM/DD/YYYY) ☐☐ / ☐☐ / ☐☐☐☐

Gender ☐ M ☐ F T

Participant's First Name ☐☐☐☐☐☐☐☐☐☐☐

MI ☐

Participant's Last Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Group Number ☐☐☐☐☐

Blue Shield ID Number ☐☐☐☐☐☐☐☐☐☐☐☐

Height

______ft ______in

Weight

___________lbs

Resting Heart Rate

_______________BPM

Blood Pressure

Systolic: ___________

Diastolic: __________

Is Blood Pressure Under 140/90

Yes No

Primary Care Provider/LiveWell Lakers approved Health Professional Attestation

I certify that I have examined the patient named above and the information is complete and accurate to the best of my knowledge. Please provide a copy of the Primary Care Provider/LiveWell Lakers approved Health Professional Attestation to the LiveWell Lakers Wellness Program Committee at Lake Superior State University human resources.

LWL HP/Provider Last Name	LWL HP/Provider First Name	National Provider Identifier (NPI)
Provider Telephone Number		Date of Appointment
Signature		Date