Atlantic Packaging Wellness Incentive Program
2024 Annual Physical with Labs/ Biometric Screening Form

NOTICE TO MEMBER

Please fill out the top portion of this form and take it to your medical provider when you complete your biometric health screening. This activity **must** occur between September 1, 2023 and August 31, 2024 to count towards the Atlantic Packaging 2024 Wellness Incentive Program activities. **Once completed by your provider, it is YOUR responsibility to return this form to Marathon Health at the contact information below.** BY COMPLETING THIS FORM AND SUBMITTING IT TO MARATHON HEALTH, YOU CONSENT TO THE DISCLOSURE BY MARATHON HEALTH TO ATLANTIC PACKAGING THAT YOU HAVE COMPLETED THE BIOMETRIC SCREENING. We will not disclose the specific results reported on this form and will use the results only to support the health services that we provide to you. You may revoke your consent to this disclosure at any time by sending us a notice in writing. Your revocation will not apply to information already disclosed by Marathon Health pursuant to this form.

TODAY'S DATE

PATIENT LOCATION

PATIENT NAME (Please Print Clearly)

DATE OF BIRTH

EMPLOYEE ID

NOTICE TO PROVIDER

Your patient has an opportunity to complete a biometric screening as a part of a wellness 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.

QUALIFYING PROGRAM ACTIVITY	DATE OF EXAM	PROVIDER INITIALS
ANNUAL PHYSICAL		
ANNUAL HEALTH SCREENING CRITERIA	**DATE TEST ADMINISTERED**	**RESULTS**
BODY MASS INDEX (BMI)		Height_____in. / Weight _____lbs
WAIST CIRCUMFERENCE		Value: _____in.
BLOOD PRESSURE		Value: _____ / _____ mmHg
TOTAL CHOLESTEROL		Value: _____mg/ dL
HDL CHOLESTEROL		Value: _____mg/dL
TRIGLYCERIDES		Value: _____mg/dL
LDL CHOLESTEROL		Value: _____mg/dL
HEMOGLOBIN A1C OR GLUCOSE		Value: _____% or _____ mg/dL

PROVIDER SIGNATURE

PLEASE PRINT (OR PROVIDER STAMP)

PROVIDER PHONE NUMBER

DEADLINES:
Forms due to Marathon Health no later than August 31, 2024.

FAX OR EMAIL YOUR COMPLETED FORM TO THE FAX NUMBER OR EMAIL ADDRESS BELOW.

Marathon Health
F: 802.419.9688
E: wellness@marathon-health.com

Marathon Health