ISAC Physician Form 2020

Have your Health Care Provider complete and sign the form below and please print clearly

First Name: _____ Last Name: _____

County: _____

City _____ Date of Birth _____Gender_____

Email address: _____ Last 4 Digits of SS# _____

The information you are submitting may be shared in aggregate form with your company for the sole purpose of administering wellness programming services or to conduct other wellness activities as permitted by law. MercyOne Business Solutions will maintain the confidentiality of your personally identifiable information and will only release personal information as permitted by law for the sole purpose of wellness program administration. At no time will your Personal Health Information (PHI) be shared with your company or an agent of your company. I authorize my data to be uploaded for incentive purposes.

Participant Signature: _____

Each item below should be filled out by your Health Care Provider

Fasting: Yes No

Blood Pressure: _____

Height: _____Weight: _____Waist Circumference: _____

Total Cholesterol: _____ HDL: _____ LDL: _____

Triglycerides: _____ Glucose: _____

_____ _____

Health Care Provider Signature **Date**

Submit one of three ways:
Mail: MercyOne Attn: AZiegler
1449 NW 128th St., Building 5, Suite 200
P.O. Box 5-6
Clive, IA 50325
Fax: 515-358-9294
Scan to: corporatehealth@mercydesmoines.org

MERCYONE ISAC Iowa State Association of Counties