



Physician Form

Have your Health Care Provider complete and sign the form below

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Employer County \_\_\_\_\_ Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender \_\_\_\_\_

Email address: \_\_\_\_\_

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:

Log into: [https://isac.livehealthyignite.com/users/sign\\_in](https://isac.livehealthyignite.com/users/sign_in) and upload under

Physical/Preventative Exam

Fax: 515-358-9294

Scan to: [corporatehealth@mercyoneiowa.org](mailto:corporatehealth@mercyoneiowa.org)

