AGH CONFIDENTIAL
BIOMETRIC SCREENING FORM

PART I - PARTICIPANT INFORMATION (TO BE COMPLETED BY PARTICIPANT - PLEASE PRINT)

Company Name

First Name | Last Name

Phone Number | Date of Birth (MM/DD/YYYY) (M M D D Y Y Y Y) | Age

Email Address

Participant ID

Biometric Screening

My initials in the adjacent box and my signature below mean that I consent to biometric screening services by my physician. **I understand that my individual screenings results will not be released to my employer UNLESS I have my biometric screening completed by my employer.** I understand that data derived from the screening does not constitute a diagnosis. The responsibility for following up with a physician as a result of health problems or high-risk indicators identified during the screening is mine. My specific screening results will be used by BHS to provide Wellness Program services to me. My specific screening results may result in communication to me by a BHS Well-Being Coach to help improve my health status if offered as a Wellness Program benefit to me. I hereby release and forever discharge, for myself, my heirs, executors, administrators, and assignees, the administers of the screenings, BHS, and my employer, their agents, representatives, employees, successors, assignees, governing bodies, and advisory committees from any and all claims, demands, actions, and causes of action which may result, including but not limited to illness or personal injury arising in any way from my screening.

Participant's Signature | Date

PART 2 - SCREENINGS (TO BE COMPLETED BY PHYSICIAN / EMPLOYEE HEALTH REPRESENTATIVE - PLEASE PRINT)

Screening Date (MM/DD/YYYY) (M M / D D / Y Y Y Y)

*Required fields

*Height (without shoes)		Inches
*Weight (without shoes)		Pounds
BMI		kg/ m^2
*Waist Measurement		Inches
Hip Measurement		Inches
*Blood Pressure	/	mmHg

Body Fat		%
*Total Cholesterol		mg/ dl
HDL Cholesterol		mg/ dl
LDL Cholesterol		mg/ dl
Triglycerides		mg/ dl
*Glucose		mg/ dl

I hereby confirm that the above results were obtained in a medical setting and are true and accurate to the best of my knowledge.

Physician's / Employee Health Representative's Name (Printed) | License #

Physician's / Employee Health Representative'sSignature | Phone Number (Provider/Clinic)

PART 3 - SUBMIT FORM

Completed Form is Due: August 31, 2024

Please mail, fax, or email completed form to:
BHS - Attn: Data Team
6225 Smith Ave, Suite 203
Baltimore, MD 21209

FAX: 410-878-6192
EMAIL: coach@bhsonline.com
ONLINE: Forms may be uploaded to your secure health portal
QUESTIONS: Call us at 877-935-5262 or email coach@bhsonline.com

Program Requirements: Completed forms must be submitted to BHS by **8/31/2024**. Acceptable date range for visits is **9/1/2023- 8/31/2024.**

Participant must complete the HRA to have his/her biometrics show within the wellness targets. A physician / Employee Health Representative signature is required to receive credit. Required fields must be completed to receive credit for completion of biometrics. Points are automtically awarded for biometric results that fall into the ideal (10 pts) or moderate (5 pts) range. See wellness point chart for details.