Physician Form

Participant Name: ______________________________
Employee Name: ______________________________
Employee ID #: ________________________________
School/Department: ____________________________
Contact Phone #: ______________________________

☐ *Check if you are the spouse of an employee*

***If you choose to have your health screening done through your physician you will need to have your physician sign and date in the box below.**

(Complete The Following 3 Steps)

1- I visited my physician and received a cholesterol test, and blood pressure check on __________ *(Date).*

____
Physician Signature

2- _____ **You will need to complete an online health risk assessment. Please contact Human Resources (801) 476-7886 for more information.**

3- _____ After completing steps 1 & 2 please submit this form to Human Resources by February 3rd, 2020. **We will not accept this form by fax!!!**

Please note:

- You only need to turn in a physician form if you choose to go to your doctor to receive the health screening. If you participate in one of Weber School District's health screenings you do not need to have this form signed.
- By participating in a health screening and completing the online health risk assessment you qualify for the wellness insurance premium for the 2019-20 plan year. The wellness insurance premium is $200 less than the regular insurance premium over the course of a year. In order to qualify for the wellness premium you need to participate in one of Weber School District's health screenings and complete the online health risk assessment ***OR*** receive a health screening through your doctor and complete the online health risk assessment. If you receive a health screening through your doctor you will need to have the doctor sign this form and turn the form into Human Resources at the District office by February 3st, 2020. Please note that due to health care coverage changes you could pay a fee for test done through your physician.
- Spouses are highly encouraged to participate but not required. Please attach a physician form for your spouse (if applicable).

Mark which incentive you would like to receive- (Employee & Retiree Only!)

___ Conversion of 2 sick days into 1 personal day
OR
___ $25

____
Employee Signature Date