STRATAIR Aviation Services

Health Screening Form

IF YOU HAVE A COPY OF YOUR LAB RESULTS	IF YOU DO NOT HAVE A COPY OF YOUR LAB RESULTS
☐ Complete *Participant Information & Signature* section	☐ Complete *Participant Information & Signature* section
☐ Obtain a copy of your lab results	☐ Have Provider complete *Health Results section*
☐ Complete *Health Results* section	☐ Have Provider complete *Provider Signature* section
☐ Submit screening form *with lab results*	☐ Submit screening form

PARTICIPANT INFORMATION

First Name ______ **MI** ___ **Last Name** ______

Date of Birth ___ / ___ / ___ (Month) (Day) (Year)

Gender ___ M/F

Unique ID ______ (Last 2 digits birth year and last 4 SSN)

Employee/Spouse ______

Daytime Phone # ___ – ___ – ____

Email Address *(Confirmation will be sent to this email address)* ______

PARTICIPANT SIGNATURE

By signing and faxing this form, I understand that my data will be shared with the administrator of the applicable wellness program. My individual results will NOT be shared with my employer. Vivacity is committed to maintaining the confidentiality of your medical information.

This form will not be accepted without a participant signature.

Participant Signature: ______________________ (Month) (Day) (Year)

HEALTH RESULTS

Height ___ ft ___ in

Weight ___ lbs

Fasting ☐ Yes ☐ No

Glucose ___

Cholesterol

HDL: ___ TRI: ___

LDL: ___ Total: ___

Blood Pressure

___ Systolic

___ Diastolic

Screening Date ___ ___ ___ (Month) (Day) (Year)

****NOTE - LAB VALUES WILL NOT BE ACCEPTED IF COLLECTED PRIOR TO 11/1/2022.**

PROVIDER SIGNATURE

! **PROVIDER INSTRUCTIONS BELOW - READ CAREFULLY** !

Complete this section by checking the appropriate screening option. Provider signature and date required.

☐ **Standard Health Screening**
I certify this patient has completed a standard health screening visit.

☐ **Preventive Visit**
I certify this patient has completed a preventive care visit (includes CDL physicals).

☐ **Exception**
I certify this patient should not complete the health screening as it is not medically necessary.

Provider Signature: ______________________ (Month) (Day) (Year)

SUBMISSION / QUESTIONS

Submit the completed fax form by **November 30, 2023**

- Fax: 1-877-657-4183
- Email: Saltchuk@vivacity.net

NOTE - Emailing data is not considered a secure form of communication

For questions regarding your health screening please contact Vivacity at **Saltchuk@vivacity.net**