Waukesha County 2025 Health Screening Program

HEALTH CARE PROVIDER VERIFICATION FORM - PROGRAM EXEMPTION

Waukesha County Employee Name:

PARTICIPANT INSTRUCTIONS:
The person seeking exemption completes the applicable boxes with their information in the top section and takes the form to their provider for the provider's assessment of the individual's ability to meet the activity-based requirements for the health insurance incentive under Waukesha County. Depending on your health care provider, you may be subject to an office visit fee for completion of this paperwork.

The employee, or if applicable spouse, (not the provider) is responsible for returning the original form to Waukesha County Human Resources no later than September 30, 2025.

Waukesha County Human Resources Address: 515 W Moreland Blvd, Rm A-160, Waukesha, WI 53188-2482
Phone: (262) 548-7044 | Fax (262) 896-8272

Participant is (Check One): ☐ County Employee ☐ Spouse Participant Name (Print):	Date of Birth:
Participant Signature:	Date Signed:

Personal information contained on this form is confidential.

The provider completes and signs the bottom section of this Health Care Provider Verification Form.

PROVIDER INSTRUCTIONS:
Health incentives are available to employees and their spouses who are covered by one of the health insurance plans offered by Waukesha County if they participate in the Health Screening Program. The program includes the following activity:

> Complete a biometric screening. The biometric screening blood draw includes a lipid panel, HbA1C, complete metabolic panel, and PSA for men over 50, and the measurements include height, weight, and blood pressure. Fasting for the blood draw will be optional.

The individual above would like your assessment of their ability to complete the activity listed above. Please indicate if, in your opinion, the individual does not have ability to complete this program due to a medical condition or because it is medically inadvisable. **Check the boxes below:**

	The individual can participate in the activity indicated.
	It is unreasonably difficult due to a medical condition, or it is medically inadvisable, for the individual to achieve the activity indicated.
	In lieu of activity listed, I recommend my patient participate in an alternative activity. This alternative includes the following:

Provider Name (Print):	Provider Phone Number:
Provider Signature:	Date Signed: