



Physician Biometric Results



Form MUST be received by August 31, 2015.

Please mail or fax this form to: The Rite Bite Corporate Wellness 171 Green Meadows Dr. South Lewis Center, OH 43035

Attn: Katie Wysong

Fax: 1-844-379-7494

reports@riteforyouwellness.com

ALL INFORMATION IS REQUIRED TO PROCESS YOUR SCREENING FORM
EMPLOYEE MUST COMPLETE SECTION 1 AND 3
HEALTHCARE PROVIDER MUST COMPLETE SECTION 2

Section 1: Participant Information (please print clearly)

Name: _____ School/Dept: _____
 First MI Last

Email: _____ Date: _____

Date of Birth: _____ Age: _____ Sex: M F Pregnant: Y N

Employee ID Number: _____

Section 2: Biometric Screening Results (to be completed by your healthcare provider)

Your healthcare provider may use biometric screening results obtained within the last 12 months

Height: _____ Weight: _____ Body Fat %: _____ BMI: _____ Waist: _____

Total Cholesterol: _____ HDL: _____ LDL: _____

Triglycerides: _____ TC/HDL Ratio: _____

Glucose: _____ Fasting Non-Fasting A1C: _____

Blood Pressure: _____ Nicotine (if applicable): _____

Healthcare Provider's Signature Date

Healthcare Provider's Name (please print) Phone

Office Address

Section 3: Participant Signature (required for processing)

Participant/Employee Signature Date

Please **DO NOT** submit this form to your Company HR department. Your healthcare provider's office must submit completed form directly to The Rite Bite. All results are strictly confidential and will not be shared with your Company. An email confirmation will be sent to you once The Rite Bite has processed your information.