



Waukesha County HRA Program BIOMETRIC SCREENING VISIT - CERTIFICATION OF COMPLETION FORM

Participant Instructions:

The HRA Program is voluntary for employees and currently enrolled spouses in the health insurance. It consists of a biometric screening, which includes (includes blood draw, height, weight, and blood pressure) in order to earn the health plan incentive for 2025. **If you would prefer to utilize your primary care provider, please take this form with your appointment to have your provider sign and date for verification of completion of your Biometric Screening Visit.** All other information is confidential and will not be shared with Waukesha County in accordance with HIPAA guidelines.

Note: You can expect that you will be required to pay for the cost of the lab work and possibly an office visit. To avoid the costs, employees and spouses are encouraged to complete the screening at the WEH&WC at no cost.

You must return this form to Waukesha County’s Human Resources Department by September 30, 2024.

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

Waukesha County Employee/Spouse Name (print): _____ **DOB:** _____

Waukesha County Employee/Spouse Signature: _____ **Date:** _____

Physician Instructions:

Health plan incentives are available to employees and their spouses who are covered by one of the health insurance plans offered by Waukesha County if they complete a Biometric Screening Visit. **Biometric Screening Visits completed between January 1, 2024, and September 30, 2024, will be accepted.**

The following are required for a Biometric Screening Visit:

- **Biometrics required:**
 - Height
 - Weight
 - Blood Pressure
- **Labs required:**
 - Glucose
 - Full Lipid Panel (to include Total Cholesterol, HDL, LDL, and Triglycerides)
 - HbA1C
 - Complete Metabolic Panel
 - PSA (Males age 50+)

By signing below, you acknowledge the above participant has completed a Biometric Screening Visit with you.

I am confirming that I have met with the named participant to complete a Biometric Screening Visit to satisfy the requirements of the Waukesha County HRA Program.

Date of Biometric Screening Visit: _____

Physician Name (Print): _____ **Physician Phone Number:** _____

Physician Signature: _____ **Date:** _____