



Dear Provider:

I, _____, have chosen to participate in a wellness program offered by my employer, the City of North Little Rock. Please record the following tests:

EMPLOYEE to Fill Out:

- 1. City Department _____ 2. DOB ____ / ____ / _____
- 3. Contact Phone Number (_____) _____ 4. Email _____
- 4. Mailing Address _____

PROVIDER's Office to Fill Out:

Weight: _____ } **BMI:** _____
Height: _____ } **-OR-**
Waist size: _____ } **Waist-to-Height Ratio:** _____
calculate by dividing waist circumference by height (both in inches)

Blood Pressure: _____

****Lipid Panel**

Total Cholesterol: _____
LDL: _____
HDL: _____
Triglycerides: _____

Tobacco Use (please check)

NONE _____
Smoke _____
Dip/Chew _____
E-Cig/Vape _____

Glucose: _____

A1C (diabetics only): _____

***Blood work should be performed from a fasting sample if possible.*

Provider's Signature

Printed Name

Date

I hereby give permission for my results to be released to City of North Little Rock authorized staff designated by the Mayor. Please mail this form to: Bernadette Gunn Rhodes, 120 Main St., North Little Rock AR 72114.

The City of North Little Rock complies with all HIPAA guidelines with regard to confidentiality.

Participant's Signature

Printed Name

Date