Healthy**OHIO**
A WellWorks initiative

CONSENT TO PARTICIPATE

As an Ohio University (OHIO) employee or spouse/partner of an OHIO employee enrolled in the health benefits, I desire to participate in Ohio University's Healthy OHIO Health Risk Appraisal program. I understand how the program works and have been provided information either in person, via email, or on the website https://www.ohio.edu/wellworks/.

I hereby give my knowing and voluntary consent to Ohio University's *Well*Works to collect my health information and to perform certain health risk appraisal screenings, including a biometric screening performed by my physician. I hereby give permission for my primary healthcare provider to complete the Physician Screening Form and return it to WellWorks to be used for my participation in Healthy OHIO. The health information being collected includes height, weight, blood pressure, waist circumference, and blood work including cholesterol, triglycerides, and blood glucose. This information will be used to inform me of my current health status; by *WellWorks,* in aggregate, to evaluate the health and wellness of OHIO employees/spouses/partners; and, to determine future programming offered by *WellWorks*.

My information will be collected by *WellWorks* as the program facilitator. *WellWorks* will share my information only with me and the University's Human Resources Benefits Office as minimally necessary (my name, employee ID, and benefit/reward) to facilitate the wellness program and my health plan benefits and rewards. *WellWorks* and Human Resources will store my information in a HIPAA compliant manner.

I acknowledge that the screening and appraisal do not substitute for the care of my primary care physician, and that it is my option and responsibility to share any results with my physician as the results will only be provided to me. I understand that it is my responsibility to follow-up with my physician regarding any abnormal lab/biometric results.

In consideration of my participation in this program, I hereby release and forever discharge Ohio University, its officers, agents, sponsors, representatives and employees from any responsibility or liability for claims arising out of any injury that I may experience or damage that I may incur as a result of my participation in this program. Further, I hereby assume all risks involved in any wellness activities and acknowledge that Workers Compensation benefits are not extended to me in my capacity as a wellness program participant. This release shall be binding on my agents, heirs, administrators, and assigns.

I acknowledge that *WellWorks* provides accommodations for the program and understand that if I need an accommodation to participate, I am to email access@ohio.edu.

I attest that I have been informed of any and all risks involved in participating in the program.

Signature: ____ Date: _________

Print Name: ______________________________________

Email: ____

OHIO UNIVERSITY

I will not be participating in the biometric screening on campus, but I hereby give permission for my primary healthcare provider to complete the Physician Screening Form and return it to WellWorks to be used for my participation in Healthy OHIO. ______________________________

(initials above).

Forms will be accepted beginning January 15, 2020 through March 31, 2020.

Revised: 08/15/2019

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Physician Health Screening Form, Regional Campuses

Dear Health Care Provider: Your patient is participating in Healthy OHIO – Ohio University's wellness initiative. Values are only valid if performed on or after April 23, 2019. Forms will be accepted beginning January 15, 2020 and must be submitted by 11:59 p.m. on March 31, 2020. Thank you for your assistance.

Completed by Healthy OHIO PARTICIPANT:

Full name: ______________________________

Date of Birth : ________/________/________

Phone: (_______) ________________________

Email: ___________________________________
OHIO employee: provide OHIO email address
Spouse/partner: provide personal email address

Verify Campus (circle one):
Athens Chillicothe Cleveland Dublin
Eastern Southern Zanesville Lancaster

If spouse/partner:
Name of OHIO employee: _______________________

OHIO employees' email: _______________@ohio.edu

Completed by HEALTH CARE PROVIDER:

REQUIRED:
Date lab values/measurements taken: _____/_____/_____ Height: ________ Weight: ________

Blood Glucose: ____________________________ Total Cholesterol: __________________________

High Density Lipoprotein (HDL): _____________ Low Density Lipoprotein (HDL): _____________

Triglycerides: ______________________________ Blood Pressure:_ ___________________________

OPTIONAL:

HbA1c: __________________________________ Waist Girth: _________________________________

____ ______________________

Health Care Professional's Signature Today's Date

Please fax completed Consent agreement and Physician Screening Form to WellWorks at 740.593.0170 or return to 1 Ohio University, Grover Center E124, Athens OH 45701.

740.593.2093
ohio.edu/wellworks
wellworks@ohio.edu

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