Healthy**OHIO**
A WellWorks initiative

CONSENT TO PARTICIPATE FORM (Form 1 of 2)

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/healthyohio.

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: _____

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)

Forms will be accepted 07/01- 05/31of each fiscal year. Instructions for submission are available on the following form.

PHYSICIAN HEALTH SCREENING FORM

Page 1 of Form 2

This page is to be completed by the Healthy OHIO participant (either the benefits-carrying employee or their benefits-enrolled spouse/partner). Your medical provider is to complete Page Two of Form Two.

Part One: Completed by Healthy OHIO PARTICIPANT:

Campus Affiliation (circle one):

Athens	Chillicothe	Cleveland	Dublin
Eastern	Southern	Zanesville	Lancaster

Full name: _____

Date of Birth : _____/_____/_____ Phone: (_____) _____

Email Address: _____

OHIO employee: provide OHIO email address. Spouse/partner: provide personal email address

If you are the spouse/partner, please provide the following:

Name of OHIO employee: _____

OHIO employees' email: _____@ohio.edu

OHIO UNIVERSITY

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PHYSICIAN HEALTH SCREENING FORM

Page 2 of Form 2

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 July 1, 2023. Forms will be accepted beginning July 1 and must be submitted by 11:59 p.m. on May 31. Thank you for your assistance.

Part Two: Completed by HEALTH CARE PROVIDER:

REQUIRED:

Patient's Name: _____ Patient's date of birth: ___/___/____

Date lab values/measurements taken: _____/_____/_____ Height:_____ Weight:___

Blood Glucose: _____ Total Cholesterol: _____

High Density Lipoprotein (HDL):_____ Low Density Lipoprotein (LDL): _____

Triglycerides: _____ Blood Pressure:_____

OPTIONAL:

HbA1c: _____ Waist Girth: _____

_____ _____

Health Care Professional's Signature Today's Date

_____

Health Care Professional's Printed Name

Instructions for Submission: Please submit completed Consent To Participate Form (1 page) AND Physician Health Screening Form (2 pages) to WellWorks at 740.593.0170 (fax) or to 1 Ohio University, Grover Center E124, Athens OH 45701 (mail/in-person). It is not recommended to submit your forms via email. Forms are accepted between July 1 and May 31 annually. We will not accept or process forms received in June.

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Phone: 740.593.2093
ohio.edu/healthy-ohio
wellworks@ohio.edu