Doctors Certificate Form Instructions

If you do not attend the Company-scheduled onsite health screenings and wish to visit your provider at another time to obtain your biometric numbers, you must also have the Data Form attached completed and faxed/received by no later than *March 31, 2020*.

Please follow these instructions to ensure that your biometric numbers are properly and timely recorded:

1. Verify the Participant Information section of the Data Form attached, and sign and date it.
2. Give or send the Data Form to your doctor and ask the doctor to fill out the Body Measurements & Biometric Results section of the form, and sign and date it. Note: the results must be from a visit to your doctor **after January 1, 2020**.
3. No other forms, lab reports, or other attachments other than the Data Form attached here may be faxed in. All Data Forms must be faxed separately, one at a time.
4. Let the doctor know that the completed Data Form must be faxed as early as possible but no later than March 31, 2020 to the fax number below. NOTE: The Data Form must be faxed directly by your provider, not by the team member:

Wellness Corporate Solutions
Attn: Information Management

SECURE FAX: 1-888-893-6729

5. OR you can upload your form electronically on the screening portal by following this link: http://boyd.wellemployeesolutions.com. Form must be in a PDF format and less than 1MB.
6. It is the team member's responsibility to ensure that their provider's office has faxed in the Data Form by March 31, 2020. If you wish to verify the receipt (only) of the Data Form by Wellness Corporate Solutions (WCS), you may call them 10 business days after your form was faxed by your provider – at 877-469-5411, M – F, 9 am – 5 pm ET. Note that there will not be any extensions to the March 31, 2020 deadline.
7. If you or your spouse wish to have an email confirmation of the receipt (only) of your Data Form by Wellness Corporate Solutions, you must clearly print your email address in the email field on the PCP form. If this is done, you should receive the email confirmation from WCS 10 business days after your form was faxed by your provider.

If you have any questions about the Data Form, please contact Wellness Corporate Solutions Customer Service at 877-469-5411, M – F, 9 am – 5 pm ET.

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DATA FORM FOR BODY MEASUREMENTS & BIOMETRIC RESULTS WITH YOUR PERSONAL PHYSICIAN

BOYD GAMING

PARTICIPANT: Complete participant information, send form to provider for completion and faxing.
PROVIDER: Complete Body Measurements & Biometric Results, sign and fax the form to Wellness Corporate Solutions at **1-888-893-6729** by **March 31, 2020**

BOYD GAMING

PARTICIPANT INFORMATION (TO BE COMPLETED BY THE PARTICIPANT) PLEASE PRINT CLEARLY

FIRST NAME (same name as on your Anthem ID card)

LAST NAME (same name as on your Anthem ID card)

DATE OF BIRTH (MM/DD/YYYY)
M M / D D / Y Y Y Y

BOYD GAMING TEAM MEMBER ID# **(REQUIRED)**

PHONE NUMBER

GENDER: ○ Male ○ Female

RELATIONSHIP: ○ Team member ○ Spouse

EMAIL ADDRESS

I understand that the purpose of my health screening is to evaluate my health status and any potential health risks, and that participation in the health screening and any affiliated wellness program is voluntary, meaning it is not required. I understand that my employer or plan sponsor cannot deny me access to health coverage or have the extent of my benefits limited, or subject me to any adverse employment action or retaliation for not participating. I confirm that prior to participating I have been presented and had the chance to review the EEOC Notice for Employer-Sponsored Wellness Programs specific to this program. I hereby request and authorize Wellness Corporate Solutions, LLC to transmit health information about me to the health management companies that provide services to my employer so that these companies may help me reduce, manage and/or control any such risks I understand that Wellness Corporate Solutions, LLC is not responsible for diagnosing, treating, or preventing any medical disease or condition that I currently have or may have in the future. I also understand that Wellness Corporate Solutions, LLC will not give me medical advice and that I must seek such advice from my own physician. I understand that Wellness Corporate Solutions, LLC will not provide my employer any health information that identifies me, except under legal exceptions allowed for administration of this program. I acknowledge and agree that Wellness Corporate Solutions, LLC may provide my employer aggregate statistical health information which includes my health information, but which does not identify me. I understand that Wellness Corporate Solutions, LLC may also use my health information for its own internal business purposes such as to develop future wellness programs or for industry research. Finally, I understand that I may faint, bruise, or have other effects as a result of my blood being drawn. By signing below I am providing prior, knowing, voluntary consent to participate in the health screening and any affiliated wellness program and accept and assume all risks associated with such participation. I hereby release and forever discharge Wellness Corporate Solutions, LLC, its owners, employees, and agents from any and all claims, demands, actions, and damages, including attorney's fees and costs, arising out of or in any way related to my participation in the health screening.

PARTICIPANT SIGNATURE (REQUIRED) DATE

BODY MEASUREMENTS & BIOMETRIC RESULTS (TO BE COMPLETED & FAXED BY PHYSICIAN, NOT TEAM MEMBER)

DATE COLLECTED
M M / D D / Y Y Y Y

FASTING STATUS: ○ Yes ○ No

*Note: Collection/office visit date must be after **January 1, 2020***

BODY COMPOSITION & BLOOD PRESSURE		BLOOD TEST RESULTS	
HEIGHT (without shoes)	feet . inches	TOTAL CHOLESTEROL	mg/dL
WEIGHT (without shoes)	. Pounds	HDL CHOLESTEROL	mg/dL
BMI	. kg/m^2	LDL CHOLESTEROL	mg/dL
WAIST	. Inches	TRIGLYCERIDES	mg/dL
BLOOD PRESSURE	/ mmHg	GLUCOSE	mg/dL
NOTES:			

ALL DATA MUST BE PROVIDED ABOVE USING PRE-DEFINED FIELDS. LAB REPORTS, OTHER FORMS OR ANY TYPE OF ATTACHMENTS WILL NOT BE REVIEWED OR PROCESSED.

PHYSICIAN SIGNATURE (REQUIRED)

/ / **SIGNATURE DATE** (MM/DD/YYYY)

PHYSICIAN NAME (PRINTED)

- - **PHONE NUMBER** (PROVIDER/CLINIC)

PLEASE FAX COMPLETED DATA FORM TO: WELLNESS CORPORATE SOLUTIONS, SECURE FAX:1-888-893-6729