We are pleased that you are participating in the "Inspiring Better Health" Wellness Screenings this year. Participation in this wellness program is confidential. Please review the instructions below, to ensure your information is complete and sent to the correct location.

STEP 1: REGISTER & COMPLETE THE SURVEY

1. Go to www.OneCommunity.com
2. *If you participated in this program last year, simply log-in using your email & password credentials. You will be asked if you want to review your results from last year or Join New. For registration purposes, click on "JOIN NEW." Follow the registration instructions and use the invitation code ISU2018. (If you cannot remember your password, click "Forgot Password" and a reset link will be sent to your email address).

   PROGRAMMING NOTE: NEW IN 2018
   For security purposes, only the user can reset a password.
   Registration prior to the screening event is highly recommended.
   Participants will need DIRECT ACCESS to their email account to reset a password at the screening event.
   ISU / Screening staff NO LONGER have the capability to reset a password for you at the screening event.
3. *If you are a "new user" this year, click on "SIGN UP" in the "Don't have an account" box and follow the registration instructions. Use the invitation code ISU2018.
4. You're all set! Now follow the instructions to complete the 5-minute health survey.

STEP 2: DETERMINE YOUR SCREENING REQUIREMENTS & SCHEDULE YOUR APPOINTMENT

PRIMARY CARE PROVIDER SCREENING OPTION - INSTRUCTIONS:

1. If you are not able to complete your screening on campus, you may see a primary care provider of your choice. Call & schedule your appointment. **You will need to fast for at least 6 hours prior to your screening; nothing to eat or drink except water and/or black coffee (no additives). Please continue to take medication, as prescribed by your physician.**
2. If you are Non-tobacco user, be sure to ask your primary care provider to note that you do not use tobacco products.
3. If you are a Tobacco-USER, you will be subject to a $50 per month tobacco-use surcharge.
4. If you are a Tobacco-USER who agrees to participate in a cessation program, this allows one to avoid the $50 surcharge for up to 2 years.

STEP 3: GET SCREENED

1. Fill out the participant information on the screening form
2. Give your screening form to the healthcare representative you've chosen & have them perform your health screening.

STEP 4: ASK YOUR HEALTHCARE PROVIDER TO COMPLETE & MAIL YOUR FORM:

1. Have your healthcare provider complete the form, by filling in the appropriate screening result values (you may need to leave your form with your healthcare provider, if lab work needs to process).
2. Let the clinic/physician know that the completed form must be mailed to the address below and received no later than October 12, 2018.
3. Your form MUST be signed by the primary care provider that completed your health screening.

Mail to: Union Hospital 1606 N. 7th St. CC. Heidi Grim Terre Haute, IN 47804 BY OCTOBER 12, 2018.

STEP 5: REVIEW YOUR RESULTS

1. You will receive an email letting you know when your results are ready. At this time, log back into www.OneCommunity.com & view your results!

If you have any questions, contact Employee Benefits at 812-237-4151 or ISU-SB@mail.indstate.edu

INSTRUCTIONS FOR RECEIVING HEALTH SCREENING

OneCommunity

SECTION 1 — PARTICIPANT INFORMATION *TO BE COMPLETED BY THE PARTICIPANT. PLEASE PRINT CLEARLY.*

First Name_____M.I._____

Last Name _____

Date of Birth_____/_____/_____ Employee I.D. 991#: 991-_____

(If you are a SPOUSE using an EMPLOYEE's 991#, be sure to add an "S" on the end of the 911#.)

Gender (Check one) ☐ Male ☐ Female Relationship (Check one) ☐ Full time ☐ Spouse ☐ Retiree

Tobacco Usage (Circle one)

I do not use any form of tobacco products.

I use tobacco products and do not plan to quit.

I use tobacco products but I am interested in a cessation plan.

I'm currently using a product to help me quit.

☐ Home Address

_____

City _____ State_____ZIP —

Contact Phone Number (_____)_____—_____E-mail Address _____

SECTION 2 — BODY MEASUREMENTS & BIOMETRIC RESULTS *TO BE COMPLETED AND MAILED BY PHYSICIAN.*

Screening Date_____/_____/_____ ☐ ☐

Fasting (Check one) Yes No

Body Composition & Blood Pressure			Blood Test Results		
Height	ft _____ in _____		Total Cholesterol		mg/dL
Weight		pounds	HDL Cholesterol		mg/dL
Waist		inches	LDL Cholesterol		mg/dL
Body Fat		%	Triglycerides		mg/dL
Systolic Blood Pressure		mmHg	Blood Glucose		mg/dL
Diastolic Blood Pressure		mmHg	Tobacco Use (circle one)	Yes	No
Notes:					

(PLEASE PRINT) NAME OF PRIMARY CARE PROVIDER/CLINIC LOCATION: _____

PRIMARY CARE PROVIDER'S SIGNATURE _____

PRIMARY CARE PHYSICIAN HEALTH SCREENING FORM