We are pleased that you are participating in the “On the Way to Wellness” Health 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 enter a new program. For registration purposes, click on “enter a new program.” Follow the registration instructions & use the invitation code ISU2015. (If you cannot remember your password, click “Forgot Password” and a temporary password will be sent to your email address).
3. *If you are a “new user” this year, click on the green “Click here to get started” button and follow the registration instructions.* Use the invitation code ISU2015. Follow the steps for first-time registration.
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**

(Choose one of the screening options below)

- **CENTER FOR OCCUPATIONAL HEALTH SCREENING OPTION – INSTRUCTIONS:**
  1. *If you are a spouse/partner who is unable to attend an on-campus screening*, you may schedule an appointment to complete your health screening at Union Hospital’s Center for Occupational Health Clinic (COH). Appointments MUST BE SCHEDULED through OneCommunity, in order to be screened at COH. Simply choose an available appointment date/time listed under the COH location within OneCommunity.
    - Address: 4001 Wabash Ave, Terre Haute, IN 47803
  2. If you are a Tobacco-USER, you will NOT need to be screened for nicotine & will be subject to a tobacco-use surcharge.
  3. If you are a Tobacco-USER who agrees to participate in a cessation program, you will NOT need to be screened for nicotine. Cessation allows one to avoid the $50 surcharge for up to 2 years.
  4. **NON-Tobacco users, must successfully complete & pass a nicotine test**
  5. The appointments are “first come-first serve,” so make sure to schedule your appointment today! If you need to reschedule your appointment, just log back into www.onecommunity.com to reschedule.

- **PRIMARY CARE PROVIDER SCREENING OPTION – INSTRUCTIONS:**
  1. If you are a remote employee who is unable to complete your screening locally in Terre Haute, 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 for water and/or black coffee (no sugar, substitute, or cream). Please continue to take medication, as prescribed by your physician.
  2. *If you are a NON-tobacco user, be sure to make your primary care office aware that you WILL need to be screened for nicotine. Non-tobacco users who do not successfully complete & pass a nicotine test, will be subject to a tobacco surcharge.*
  3. If you are a Tobacco-USER, you will NOT need to be screened for nicotine & will be subject to a tobacco-use surcharge.
  4. If you are a Tobacco-USER who agrees to participate in a cessation program, you will NOT need to be screened for nicotine. Cessation 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 29th of 2015.
3. Your form MUST be signed by the primary care provider that completed your health screening.

<table>
<thead>
<tr>
<th>Mail to: Union Hospital Center for Occupational Health</th>
<th>4001 Wabash Ave.</th>
<th>CC: James Twitchell</th>
<th>Terre Haute, IN 47803</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BY OCTOBER 29TH 2015</strong></td>
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</tbody>
</table>

**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, please contact Lauren Campbell:
812-237-4117 or Lauren.Campbell@indstate.edu

**INSTRUCTIONS FOR RECEIVING HEALTH SCREENING**
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 (Check one)

☐ I do not use any form of tobacco products. (TEST FOR COTININE)

☐ I use tobacco products and do not plan to quit. (DO NOT test for cotinine)

☐ I use tobacco products but I am interested in a cessation plan. (DO NOT test for cotinine)

☐ I'm currently using a product to help me quit. (DO NOT test for cotinine)

Home Address ____________________________________________________________

City________________________________________________________State_________ZIP_________

Contact Phone Number (______) _______—________  E-mail Address__________________________

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

Screening Date _____ _____/_____ _____/______ ______  Fasting (Check one)  ☐ Yes  ☐ No

<table>
<thead>
<tr>
<th>Body Composition &amp; Blood Pressure</th>
<th>Blood Test Results</th>
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</thead>
<tbody>
<tr>
<td>Height</td>
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<tr>
<td>ft_________in__________</td>
<td>mg/dL</td>
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<tr>
<td>mmHg</td>
<td>Positive/Fail</td>
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<tr>
<td>(circle one)</td>
<td>Negative/Pass</td>
</tr>
</tbody>
</table>

Notes:

(Please print) Name of Primary Care Provider/Clinic Location: ________________________________

Primary Care Provider's Signature ________________________________________________

PRIMARY CARE PHYSICIAN HEALTH SCREENING FORM