



**Instructions:** Please complete the form below and submit it to Vitality™ with proof of your Vitality Check results. This proof can include ONE of the following:

- A health care practitioner’s signature in Section C of this form OR
- A copy of your screening results from your physician’s office

Vitality Points™ will be awarded for each Vitality Check measure you complete. If your results are in a healthy range, you will earn additional Vitality Points. You will be eligible for participation and in-range points once per program year. Please note that submitting your biometric results will automatically update your Vitality Health Review™.

**We encourage you to submit this activity online.** Simply log into your Vitality account, navigate to **Home > Submit Activity**, select your activity and follow the prompts to submit your information and supporting documentation. Alternatively, you may email your submission to [wellness@powerofvitality.com](mailto:wellness@powerofvitality.com) or fax it to **877.224.7110**.

<b>Section A: Member’s Information</b>	
First Name of Member who Completed the Activity:	Last Name of Member who Completed the Activity:
Vitality ID:	Date of Birth:

<b>Section B: Biometric Screening Results</b>					
<b>Blood Pressure</b>			<b>Body Measures</b>		
Systolic:	Diastolic:	Height:	Weight:		
		inches	lbs		
mmHg	mmHg	Waist:	inches		
<b>Clinical Laboratory</b>					
Fasting Blood Glucose:	Total Cholesterol:	LDL Cholesterol:	HDL Cholesterol:	Triglycerides:	Date of Screening(s):
mg/dL	mg/dL	mg/dL	mg/dL	mg/dL	
I am including the following as proof of my Vitality Check completion ( <i>check one</i> ):					
<input type="checkbox"/> A health care practitioner’s signature in Section C of this form			<input type="checkbox"/> A copy of my screening results from my physician’s office		

<b>Section C: Physician and/or Facility Information and Certification of Results</b>	
Health Care Practitioner and/or Facility Name:	Address:
National Provider ID or CLIA Number:	Phone or Email:
<b>Certification of Results:</b> I certify that I personally conducted this member’s cotinine screening and attest to the accuracy of the results reported herein.	
Health Care Practitioner’s Signature ( <i>if no other proof of activity is included</i> ):	Date of Signature:

<b>Section D: Member’s Declaration and Consent</b>	
By signing this form, I attest that I completed this Vitality Check as listed above and that the information submitted with this request is accurate and complete. I consent and agree that Vitality or any of its representatives has the right to verify and review information to substantiate information and representations herein for the purpose of awarding Vitality Points.	
Member’s Signature:	Date of Signature:

**Notice of Reasonable Alternative Standard:** If it is medically inadvisable or not plausible for you to meet Vitality’s healthy range standards, you may complete and submit the Biometrics Physician Waiver or, if you are currently pregnant, the Prenatal Care Verification Waiver. Doing so will allow you to earn Vitality Points in the Healthy Measures category that you otherwise may not be eligible to receive. To access these forms, please log into your Vitality account and navigate to **Forms > Medical Accommodations / Waivers**.

Questions? Please feel free to contact a Vitality Customer Care representative at **877.224.7117** or [wellness@powerofvitality.com](mailto:wellness@powerofvitality.com).