LIVESMART O'NEAL INDUSTRIES | 360°

Qualification Form

O'Neal Industries/Affiliate Company Employee or Spouse instructions:
- Complete this part of the form and take it to your physician to complete.
- Fax or mail the completed form to (205) 978-3760 or LIVE**SMART** Health and Wellness Program • PO Box 660225 • Birmingham, AL 35266-0225.
- It is the participant's responsibility to submit via mail or fax or verify submission by your physician.

Last Name:	First Name:	
☐ Employee ☐ New Hire (within 30 days of receiving benefits) ☐ Spouse Employee Name: _____	Company _____	Work City/State _____
Day Telephone ( ) -	Date of Birth (MM/DD/YYYY) / /	Gender (Check One) ☐ Male ☐ Female
Participant Signature _____	E-mail Address _____	

Physician Instructions:
- Complete all fields below, and sign this form.
- Return the form to the employee/member for submission to the LIVE**SMART** Wellness Program or fax to (205) 978-3760.
- If the employee/member does not meet one or more of the health measure criteria listed below, document the goals and patient actions in the member health improvement plan on the 2nd page of this form.

HEALTH MEASURE CRITERIA GOAL		EMPLOYEE/MEMBER'S MEASUREMENTS	
Tobacco Use Non-tobacco user (never used or quit > 6 months)		☐ Non-tobacco user ☐ Tobacco User	**Type:** ☐ Cigarettes ☐ Cigars ☐ Smokeless
VITALS	**Height/Weight**	**ON MEDICATION**	Height: . inches Weight: pounds
VITALS	**Blood Pressure**	☐ Yes ☐ No	BMI: . BP: /
LABS	**Triglycerides**	☐ Yes ☐ No	Triglycerides:
LABS	**Cholesterol**	☐ Yes ☐ No	LDL: HDL: Total:
LABS	**Blood Glucose**	☐ Yes ☐ No	FBG: (include value for individuals with/without diabetes) A1C: . % (diabetic)

Note: Your LIVE**SMART** wellness program is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees and spouses. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same rewards by different means. Contact us at (888) 501-1252 or livesmart@onealind.com and we will work with you (and if you wish, your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

Physician Last Name:	Physician First Name:	City & State
Physician Address:	Physician Telephone Number:	Exam Date: / /

Physician Instructions:

If the member does not meet one or more of the health measure criteria listed below, document the member health improvement plan below.

The member health improvement plan must include:

- ✓ **Goals of the Plan**
- ✓ **Patient actions to modify behavior, lifestyle or adherence to medical recommendations**
- ✓ **Follow up visit plan established in accordance with physician recommendations**

SELECT HEALTH RISK(S)	GOAL HEALTH MEASURE CRITERIA
☐ Tobacco Use	No tobacco use
☐ Weight Loss	BMI < 25
☐ Blood Pressure Control	< 120/80 (both systolic and diastolic)
☐ Cholesterol and Triglyceride Lowering	LDL <160, HDL > 40 Total Cholesterol < 200, Triglycerides < 150
☐ Blood Glucose/Diabetes Management/Control	Normal fasting blood sugar OR patients with diabetes A1C < 7%
☐ Sedentary Activity	30 minutes, 5 days a week

Goals:

1.

2.

Patient Actions:

1.

2.

Recommendations for follow-up visit:

1.

2.

Physician Signature: I verify the information is complete and accurate.

Physician Last Name	Physician First Name
Member Last Name	Member First Name

Fax completed form to: 1-205-978-3760 • Questions please call 1-888-501-1252