Biometric Data Reporting Form

Employee Name:

Employee #: Email:

Department/Division:

Telephone #: Date:

I, ____________________ grant permission to Dr. ________________ to share certain elements of my health information, specifically **the date of my exam**, with the Human Resources department of the City of Cleveland. This release will be in effect for one year from the date signed. I understand I may retract this permission at any time either verbally or in writing. Patient signature: _____________________Date: _____________________

Biometric Measures	Test Date
Current Body Weight	Test date only:
Height	Test date only:
Body Mass Index	Test date only:
Blood Pressure Level	Test date only:
Cholesterol Level	Test date only:
High-Density Lipoprotein (HDL)	Test date only:
Glucose Level	Test date only:
Abdominal Circumference (in inches)	Test date only:

Biometric Screening Certified by:

____

(Signature/Stamp of Physician or Lab)

Please print the provider's name and phone number:

____

RETURN FORM TO:

City of Cleveland, Department of Human Resources

Attention: Kelley Smith, Human Resources Administrator

601 Lakeside Avenue Rm. 121