Good For You!

BIOMETRIC SCREENING FORM

PARTICIPANT:

You must submit this form no later than 6/15/2026 to earn your incentive.
Exam must have been performed between 7/1/2025-6/15/2026 to qualify for the incentive.
Request a copy of the completed form for your records.

Participant Name (print legibly):	
Date of Birth (MM/DD/YYYY):	
Employee Name:	

PROVIDER:

Please sign this form verifying that your patient received a preventive physical exam including weight, blood pressure, full lipid panel, and glucose.

Provider Name:		Phone:	
Provider Address:		Provider License #:	
Provider Signature:		Exam Date:	

Health Screening Measures	Participant Status	Notes
Height	_____ ft. _____ in.	
Weight (without shoes)	_____ lbs.	
Waist	_____ in.	
Blood Pressure	_____ / _____ mm/Hg	
Body Mass Index	_____ %	
Total Cholesterol	_____ mg/DL	
HDL	_____ mg/DL	
LDL	_____ mg/DL	
Triglycerides	_____ mg/DL	
Glucose ☐ Fasting ☐ Non-fasting	_____ mg/DL	

TO SUBMIT COMPLETED FORM

A clear picture from a smartphone is acceptable.

Portal Upload	www.corehealthylife.com/**GoodForYou**

If you have questions regarding your form submission, you may call the American Institute for Preventive Medicine (800-345-2476 and press 4).