

MEDICAL WAIVER FORM

2020

www.assethealth.com/frisco

Submit By: October 31, 2020

① Employee Information:

Last Name: _____ First Name: _____

Date of Birth (mm/dd/yyyy): ____/____/____ Employee ID: _____

Phone: _____ Email: _____

② Reason:

Waive Biometric Requirement Due to Medical Reasoning:

The individual has a health factor that makes it unreasonably difficult for the individual to satisfy or medically inadvisable to attempt to satisfy the otherwise applicable standard.

③ Provide Consent:

The information supplied here by myself or by my representative is true to the best of my knowledge. I authorize the physician indicated below or his/her authorized office staff to release my confidential medical information to Asset Health. By signing below, I acknowledge that I have read and accepted the ADA and GINA notice provided in its entirety.

Date: _____

Employee Signature: _____ Employee Printed Name: _____

④ To be Completed by Your Healthcare Provider:

Key Health Target	Please identify all risk categories that you are requesting the patient to be waived from as they are under your care
HDL: \geq 40 mg/dL (male) / \geq 50 mg/dL (female)	
Triglycerides: < 150 mg/dL	
Blood Pressure: < 130/85 mmHg	
Fasting Glucose: < 110 mg/dL	
Waist Circumference: < 40 in. (male) / < 35 in. (female) OR BMI \leq 25	

Physician Phone Number: _____

Physician Signature: _____ Date: _____

⑤ Send Form To:

Asset Health
Upload: assethealth.com/frisco
Fax: 248-816-3326
Mail: 2250 Butterfield Drive, Suite 100 Troy, MI 48084

