MEDICAL WAIVER REQUEST FORM

Wayland Baptist University offers a reasonable alternative to the biometric improvement standards under the 2016-2017 wellness program for participants with medical conditions.

The reasonable alternative allows the participant to **bypass the biometric improvement requirement** in exchange for completing **1 education credit** by ***July 15, 2017***.

Please complete and email this form to MercyCareBHS@mercycare.org by ***11:59 p.m. June 30, 2017*** in order to apply for the reasonable alternative option. All other wellness program requirements must be completed by their respective deadlines.

Name _____ Campus Location _____

Date _____ Phone _____

Wellness ID _____ Email _____

Please select the following risks for which you are requesting a medical waiver:

☐Blood Pressure
☐Waist circumference
☐Glucose
☐HDL
☐Triglycerides

I am unable to meet the biometric improvement standards under the 2016-2017 WBU wellness program and am requesting an alternative in order to achieve the medical insurance discount. By completing and signing this form I acknowledge that I understand the requirements and deadlines as stated above and that if I do not meet these requirements and deadlines, I will not be eligible to receive the 2016-2017 medical insurance discount.

_____ SIGN HERE
Participant Signature Date

CONSENT TO RELEASE OF HEALTH INFORMATION

I hereby voluntary authorize MercyCare Business Health Solutions to disclose the health information contained in this document to the Human Resources staff at Wayland Baptist University in order to authorize the reasonable alternative to the biometric improvement standard.

I understand that if the entity authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. This authorization is effective for six months from the date on which it was signed. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it, by giving written notice to MercyCare Business Health Solutions. I understand that I have a right to inspect the information to be disclosed.

_____ SIGN HERE
Participant Signature Date

MERCYCARE BUSINESS HEALTH SOLUTIONS

MercyCareBHS@mercycare.org | (319) 369-4455