

FRED SMITH COMPANY
REASONABLE ALTERNATIVE STANDARD FORM

Employee First Name: _____ Last Name: _____

Date of Birth: _____ Fred Smith Employee ID#: _____

Phone Number: _____

Email: _____

By submitting and signing this form, I verify that the information supplied is true and complete, and there has been no attempt to knowingly provide any false, incomplete, or misleading information.

Participant Signature: _____ Date: _____

Biometric value that fell outside of the company's wellness program goals: (please check all that apply)

- Elevated BMI
- Elevated Blood Pressure
- Elevated Blood Glucose
- Tobacco Use

TO BE COMPLETED BY PRIMARY CARE PROVIDER

The signature below certifies that you are the primary care physician/PA/NP of the above-named individual and that you have identified and discussed appropriate recommendations or treatments to address the biometric value that did not meet the Fred Smith Company's wellness program goals.

Primary Care Provider Name (printed): _____

PCP Signature: _____

Practice Name: _____

PCP Office Phone Number: _____ Date: _____

PLEASE NOTE: It is the employee's responsibility to submit this form via secure email, fax or mail to:

Email: MobileWellness@wakemed.org **Mail:** Liza MacDonald, Corporate and Community Health
3000 New Bern Ave.
Fax: 919-350-6739 Raleigh, NC 27610

Questions? Liza MacDonald (se habla español) at MobileWellness@wakemed.org or 919-350-5909.