Must be submitted by May 15, 2026

Alternate Biometric Screening Form
Forsyth County Government Wellness Program

To be completed by Wellness Program participant:

Participant Name: _____

Gender: _____ Date of Birth: _____ / _____ / _____

Address: _____

Telephone #: _____ Email: _____

Employee ID (Retirees): _____ Last 4 of SSN (Spouses): _____

To be completed by healthcare provider (all fields are required):

Date of Biometric Collection: _____ / _____ / _____

Height: _____ ft. _____ in. Weight: _____ lbs

Blood Pressure: _____ / _____

Waist circumference: _____

Date of Lab Draw: _____ / _____ / _____

Total Cholesterol: _____

HDL: _____ LDL: _____ Triglycerides: _____

Glucose: _____ A1C: _____

Fasting: **Fasting** or **Non-Fasting** (circle one)

Printed name of healthcare provider: _____

Signature of healthcare provider: _____

NPI: _____ Date / Time: _____

Once completed, please:
Fax this form Attention: Emily Stiehl to (336) 716-1635 or
Scan and email to FCGWellnessAHWFB@AdvocateHealth.org or
Mail to Emily Stiehl at, Work and Campus Care Solutions, Box 573232, Medical Center Blvd, Winston-Salem, NC 27157