

**LORAIN COUNTY COMMUNITY COLLEGE  
PREVENTIVE CARE VERIFICATION FORM**

Dear Doctor:

My employer, Lorain County Community College, will provide me with a discount on my medical insurance premiums, if on an annual basis I complete an online health risk assessment and receive some type of age and/or gender specific preventive health care ordered by my physician.

Below for your reference is the list of tests for which the college's medical plans will provide **100% coverage**, if ordered as **routine/preventive care** and not in association with a medical diagnostic code. **You may order any one or more of the following tests you deem appropriate, in order for me to be considered as having received some type of preventive health care:**

EKG	Metabolic Panel	PSA Test
CBC	Urinalysis	Pap Test
Lipid Profile	Fecal Occult Blood Test	Mammogram
Fasting Glucose		CA 125 Test

The college's medical plans also provide coverage at **90%**, subject to the deductible for a routine colonoscopy at age 50 and every 5 years thereafter.

**Please verify below that I have received some type of age and/or gender specific preventive health care during the current calendar year, by signing below. Please do not indicate what type of preventive health care I received or the results of any routine tests that have been or may be performed, as the college does not need or want access to that information. Thank you.**

\_\_\_\_\_ has received preventive health care during \_\_\_\_\_  
**Employee/patient** **Year**

\_\_\_\_\_  
**Physician Name (Please print)** **Physician Signature** **Date**

\_\_\_\_\_  
**Employee Name (Please print)** **Employee Signature** **Date**

The college will also provide me with an additional premium discount if I sign an affidavit stating that I do not use tobacco products and if I have three of the five factors, which contribute to Metabolic Syndrome, under control. Those five factors, along with their recommended standards are listed below:

Waist circumference	$\leq 35''$ for women and $\leq 40''$ for men
Triglycerides (level of blood fat)	$\leq 150$ mg/dL
HDL (good cholesterol)	$\geq 50$ mg/dL for women and $\geq 40$ mg/dL for men
Blood pressure	$\leq 130/85$
Glucose (blood sugar)	$\leq 100$ mg/dL

For purposes of the discount, the college will consider me to have these factors under control even if I am doing so with the assistance of medication.

**Please verify whether or not I have at least three of the five factors which contribute to Metabolic Syndrome under control, by signing below. Please do not indicate what my biometric measurements are or which factors I have or have not met, as the college does not want or need access to that information. Thank you.**

\_\_\_\_\_ does / does not (please circle) have at least three of the five  
**Employee/patient** factors which contribute to metabolic syndrome under control.

_____	_____	_____
<b>Physician Name (Please print)</b>	<b>Physician Signature</b>	<b>Date</b>

_____	_____	_____
Employee Name (Please print)	Employee Signature	Date

**Please return this form directly to me and I in turn will forward it to the college. Thank you.**