

Participant Instructions: Exams and lab tests must be performed between 10/1/2025 - 9/30/2026. Participant to complete the top portion of the form. Health Care Provider to complete the bottom portion.

Upload your completed form within your Kapnick Strive wellness portal at www.kapnickstrive.com/henniges OR FAX to 888-975-5086. Forms must be received by Kapnick Strive no later than 9/30/2026.

Questions: Contact Kapnick Strive at strive@kapnick.com or 877-233-2296

FIRST NAME	LAST NAME
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GENDER	☐	MALE	☐	FEMALE
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PRIMARY PHONE #	DATE OF BIRTH
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By signing below, I consent to the participation in the wellness program, associated screenings and to the release of my medical information to Kapnick Strive. I understand that my participation is voluntary, and my employer will not receive my results. I consent that the information on this form is complete and accurate.

PARTICIPANT SIGNATURE: _____

Health Care Provider: Your patient's employer is offering a wellness program with the required screenings listed below. To ensure your patient receives their incentive, please complete all labs, biometric measures, and fields on the form, then return it to the patient. Incomplete forms cannot be accepted.

DATE OF EXAM	FASTING STATUS ☐ YES ☐ NO
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WAIST CIRCUMFERENCE _____ inches	WAIST CIRCUMFERENCE TARGET RANGE MEN: ≤ 40 INCHES WOMEN: ≤ 35 INCHES
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BLOOD PRESSURE SYSTOLIC _____ mm Hg DIASTOLIC _____ mm Hg	BLOOD PRESSURE TARGET RANGE SYSTOLIC: < 130 mm Hg DIASTOLIC: < 85 mm Hg
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HIGH DENSITY LIPOPROTEIN (HDL) _____ mg/dL	HDL TARGET RANGE MEN: ≥ 40 mg/dL WOMEN: ≥ 50 mg/dL
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TRIGLYCERIDES _____ mg/dL	TRIGLYCERIDES TARGET RANGE < 150 mg/dL
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FASTED BLOOD SUGAR GLUCOSE _____ mg/dL	FASTING GLUCOSE TARGET RANGE < 100 mg/dL
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ADDITIONAL COMMENTS

Provider Signature: By signing below, I verify the information above is complete and accurate. PROVIDER PRINTED NAME	PROVIDER PHONE #
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PROVIDER SIGNATURE	DATE
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