VSC
VERMONT STATE COLLEGES

IN ORDER TO COMPLETE A HEALTH ASSESSMENT, I NEED THE FOLLOWING INFORMATION:

1. Total Cholesterol _____ 2. HDL Cholesterol _____

3. Blood Pressure (Systolic)_____ 4. Blood Pressure (Diastolic_____

5. Weight_____ 6 . Height _____ 7. Waist Circumference_____

Preventive Screenings

☐Pap Test – Date _____ ☐Mammogram- Date _____

☐Colon Cancer Screen- Date _____ ☐Prostate Exam- Date _____

☐Tetanus Shot –Date _____

☐Other Screenings –_____

Please remove this portion and present to your Human Resources Director to receive a stipend of $25.00.

I, _____, certify that I have visited my physician on _____.
And have received the appropriate testing to obtain the results needed to complete the CIGNA Health Assessment.

_____	_____	_____
Physician Name	Physician Signature	Date
_____	_____	_____
Participant Name	Participant Signature	Date
_____	_____	_____
Employee Name	Employee Signature	Date