IMPORTANT: If the form is not filled out or printed correctly, there will be a delay in the processing of your results.* There will also be a delay if you include any additional pages other than the form on the following page.

PRINTING INSTRUCTIONS

<table>
<thead>
<tr>
<th>DO</th>
<th>DON'T</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bring the original form to the doctor's office.</td>
<td>DO NOT FAX A COPY OF THE FORM TO YOUR DOCTOR. Your form will not be processed correctly.</td>
</tr>
<tr>
<td>Print form on an 8.5” x 11” paper.</td>
<td>DO NOT SHRINK OR SCALE YOUR FORM IN ANY WAY WHEN PRINTING. Your form will not be processed correctly.</td>
</tr>
</tbody>
</table>

FORM SUBMISSION INSTRUCTIONS

1. Have your healthcare provider complete and sign the form on page 2.

2. Submit the signed form via one of two secure methods (either you or your healthcare provider’s office can complete this step):
   • Scan your completed form and upload at http://forms.wellmetrics.life/submission. This is the recommended submission method – please remind your healthcare provider to use your email address associated with the wellness program to receive confirmation of submission.
   • Fax to (866) 877-7095.

3. Keep a copy of the successful transmission for your records.

Note: Please do not include the cover page of the form in your submission. Only page 2 is required. *Please allow 72 hours for your health screening results to be reflected in your account. Questions? Contact support@adurolife.com.
# Health Provider Screening Form

**NOVAfit!**

**Verification**

1. Please read the instructions and complete ALL fields like this:
2. You must have your doctor or doctor’s office complete and sign this form.
3. Fax the form to: **(866) 877-7095** or upload at http://forms.wellmetrics.life/submission.
4. It is your responsibility to make sure this form is submitted.

**Completion Directions**

**PRINT CLEARLY**

**EMPLOYEE**

**First Name**

**Middle Name**

**Last Name**

**Employee ID (if known)**

**Date of Birth**

**Gender:**

- [ ] Male
- [ ] Female

**I hereby certify** that I have not used any cigarettes, cigars, pipes, snuff, chewing tobacco, nicotine gum or other tobacco or nicotine delivery system in the last 6 months (mark one below).

- [ ] Agree
- [ ] Disagree

**By signing this form, I certify the following:** I have truthfully checked the Agree or Disagree box that accurately reflects my use of tobacco/nicotine and I understand that tobacco products include cigarettes, cigars, chewing or pipe tobacco, nicotine gum or any other tobacco or nicotine products regardless of the frequency or method of use.

**Signature**

**Print Name**

**Phone #**

---

*** FOR PHYSICIAN OR OFFICE STAFF USE ONLY BELOW THIS LINE ***

**Height**

**Weight**

**Fasting**

**Waist**

**Date Tested**

**Blood Pressure**

- **Systolic**
- **Diastolic**

**HDL Cholesterol (mg/dL)**

**Total Cholesterol (mg/dL)**

**LDL Cholesterol (mg/dL)**

**Triglycerides (mg/dL)**

**Glucose (mg/dL)**

---

**Facility Name**

**Certifying Agent Name**

**NPI #**

**Date**

**Agent Signature**

**Phone #**

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**Questions?** Please contact us at support@adurolife.com

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