



**City of North Myrtle Beach Wellness Incentive Plan
Reasonable Alternative Standard Request**



Participant Name:	Participant Birthdate:
Phone number:	Email Address:

Have your health care provider complete this form and include details in all relevant sections below:

WIP Goal	Check all that apply	There is a valid reason goal is not met and employee is in compliance with medical prescribed treatment (Provide Details)	Employee is not in compliance with medical prescribed treatment and clinic coaching is preferred (Provide Details)
BMI < 30	<input type="checkbox"/>		
Blood Pressure <140/90	<input type="checkbox"/>		
Blood Glucose < 100	<input type="checkbox"/>		
HDL ≥ 40	<input type="checkbox"/>		
LDL < 130	<input type="checkbox"/>		
Triglycerides < 200	<input type="checkbox"/>		



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Tobacco Free	<input type="checkbox"/>		
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Other Issue or Concern	
Employee Signature and Date	
Health Care Provider Signature and Date	

This form must be completed and returned, along with appropriate documentation, to the City of NMB Health Center by November 15, 2020.

Completed form and verification documentation may be faxed to (843) 281-3834.