



DATE RECEIVED	APPROVED	\$
#	OFFICE USE ONLY	

Name: _____ Phone: _____ Date: _____

E-mail: _____ School District: _____

Healthy Lifestyle Solutions Incentive Program Verification Form 2009/10

Please complete this verification form and return it with your personal exercise log and smoke free pledge (if applicable) to MCSIG by May 30. You can only claim credit for activities completed during the program year (July 1 - June 30), except as indicated below.

Check those items you are claiming Health Action credit for the 2009/10 program.

You Check	Health Action	MCSIG Verifies
<input type="checkbox"/>	I completed a required wellness assessment (health risk appraisal & health screenings) during the program award year (July 1-June 30). Date: _____	<input type="checkbox"/>
<input type="checkbox"/>	I received a complete physical exam from my physician per the MCSIG Schedule of Visits for my Age Group. Date of exam: _____ * Credit may be given for a complete physical exam performed per schedule by age prior to the award year (6 months) with documentation.	<input type="checkbox"/>
<input type="checkbox"/>	I performed the listed physical activities on the Personal Exercise Log sheet (www.mcsig.com) for a maximum of 60 minutes (2 credits) per day. 180 credits total required per 12 months.	<input type="checkbox"/>
<input type="checkbox"/>	I have not smoked or used tobacco for the last five years and have attached my signed Tobacco-Free Pledge (www.mcsig.com).	<input type="checkbox"/>
OR		
<input type="checkbox"/>	I quit smoking and have not used tobacco for the last 12 months and have attached a Smoking Cessation Class Certificate.	<input type="checkbox"/>
<input type="checkbox"/>	My Body Mass Index (BMI) score was 30 or less at the time of the wellness assessment.	<input type="checkbox"/>
OR		
<input type="checkbox"/>	I attended Weight Watchers and was reimbursed by MCSIG.	<input type="checkbox"/>
<input type="checkbox"/>	I received a flu shot or nasal-spray flu vaccine at a MCSIG flu shot clinic or from a doctor. Receipt required if vaccine not given by MCSIG. Flu clinic _____	<input type="checkbox"/>

**You
Check**

Health Action

**MCSIG
Verifies**

I **participated** in one or more of the MCSIG health promotion programs listed below.

Check the programs you participated in between July 1 and May 30. Activities can be added for additional credit. Activities may vary from year to year.

- 10K-A-Day 2009* (Sept.) Exercise Challenge 2010* (Feb.) Health Fair 2010* (May)
 Wellness Advisory Committee* Wellness Ambassador*
 Other _____

*Must meet minimum participation guidelines to receive points.

I participated in a **Community Event** (walk, run or triathlon) and have attached a copy of of my registration or event bib number.

I attended a **self-directed learning class(s)** at a participating hospital and was reimbursed by MCSIG. Check the class(s) you participated in:

- Yoga Flow Meditation Tai Chi
 Child Birth Preparation Stress Management
 Prenatal Yoga Fresh Start (quit smoking)
 Breast Feeding Asthma Education
 Diabetes Heart-Smart Nutrition Walk and Win
 Other _____

My **blood pressure** reading was **139/89** or less at the MCSIG health screening or I completed a training course on reducing blood pressure.

My **cholesterol ratio** (TC/HDL) was **4.5** or less at the MCSIG health screening or I completed a training course on cholesterol control.

My **glucose reading** was **140** or less at the MCSIG health screening or I completed a training course on ways to reduce blood sugar.

(TOTAL POSSIBLE ACTIVITIES = 13)

Actions Verified

Signature

Comments: _____
