Physician Certification Form

The Cleveland Metropolitan School District has established a wellness incentive for eligible participants that complete certain activities. This form must be uploaded to your PeopleOne Health wellness portal by **October 31, 2025.** Note: If you are a new hire, you have 60 days from the start of your benefits to upload this form.

To qualify the employee and covered spouse, if the spouse is covered as primary under a CMSD health plan, must submit an annual physician certification of having completed the listed activities. **Please note: The actual results, diagnoses and/or any other details of any testing or assessment are not to be included with this form.**

Please submit employee and spousal form separately under own unique wellness portal login. If spouse of CMSD employee, please specify your spouses name below.

Patient First Name	Patient Last Name	Patient Date of Birth
Policy Holder First Name (if different from above)	Policy Holder Last Name (if different from above)	Policy Holder Date of Birth
CMSD Employee ID Number		
Certifying Physician Name		

1) The patient named above has completed a screening during the period of 11/1/2024-10/31/2025 that, at a minimum, include the following: • Cholesterol Screening • Glucose Screening • Blood Pressure Screening • Body Mass Index (BMI)	Yes _____ No _____
2) The patient named above completed and submitted the CMSD Physician Health Risk Assessment to me during the period of: 11/1/2024-10/31/2025.	Yes _____ No _____

Physician/Physician Assistant/Nurse Practitioner Signature Date

DO NOT SUBMIT THIS FORM TO ANYONE OTHER THAN YOUR HEALTHCARE PROVIDER

CLEVELAND METROPOLITAN SCHOOL DISTRICT

Physician Health Risk Assessment

This Health Risk Assessment should be completed and shared with your physician. Your physician will need to certify completion of this Health Risk Assessment for qualification of wellness premium incentives.

Name	
Date of Birth	Date of HRA Completion
In the past 7 days, how many days did you exercise?	Days
On the days when you exercised, for how long did you exercise (in minutes)?	Minutes
How intense was your typical exercise? ❒ Light (like stretching or slow walking) ❒ Moderate (like brisk walking) ❒ Heavy (like jogging or swimming) ❒ Very heavy (like fast running or stair climbing) ❒ I am currently not exercising	
In the last 30 days, have you used tobacco? Smoked Tobacco Product: ❒ Yes ❒ No Smokeless Tobacco Product: ❒ Yes ❒ No	If yes to either, would you be interested in a tobacco cessation plan? ❒ Yes ❒ No
In the past 7 days, on how many days did you drink alcohol?	Days
On days when you drank alcohol, how often did you have 3 or more for men, 2 or more for women alcoholic drinks on one occasion? ❒ Never ❒ Once during the week ❒ 2–3 times during the week ❒ More than 3 times during the week	
In the past 7 days, how many servings of fruits and vegetables did you typically eat each day? (1 serving = 1 cup of fresh vegetables, ½ cup of cooked vegetables, or 1 medium piece of fruit. 1 cup = size of a baseball.)	Servings
In the past 7 days, how many servings of high fiber or whole grain foods did you typically eat each day? (1 serving = 1 slice of 100% whole wheat bread, 1 cup of whole-grain or high-fiber ready-to-eat cereal, ½ cup of cooked cereal such as oatmeal, or ½ cup of cooked brown rice or whole wheat pasta.)	Servings
In the past 7 days, how many servings of fried or high-fat foods did you typically eat each day? (Examples include fried chicken, fried fish, bacon, French fries, potato chips, corn chips, doughnuts,	Servings

creamy salad dressings, and foods made with whole milk, cream, cheese, or mayonnaise.)	
In the past 7 days, how many sugar-sweetened (not diet) beverages did you typically consume *each day*?	Servings

Do you always fasten your seat belt when you are in the car?

❒ Yes ❒ No

In the past 2 weeks, how often have you felt down, depressed, or hopeless?

❒ Almost all of the time ❒ Most of the time ❒ Some of the time ❒ Almost never

In the past 2 weeks, how often have you felt little interest or pleasure in doing things?

❒ Almost all of the time ❒ Most of the time ❒ Some of the time ❒ Almost never

Have your feelings caused you distress or interfered with your ability to get along socially with family or friends?

❒ Yes ❒ No

In the past 2 weeks, how often have you felt nervous, anxious, or on edge?

❒ Almost all of the time ❒ Most of the time ❒ Some of the time ❒ Almost never

In the past 2 weeks, how often were you not able to stop worrying or control you're worrying?

❒ Almost all of the time ❒ Most of the time ❒ Some of the time ❒ Almost never

How often is stress a problem for you in handling such things as:

Your health: ❒ Never or rarely ❒ Sometimes ❒ Often ❒ Always

Your finances: ❒ Never or rarely ❒ Sometimes ❒ Often ❒ Always

Family/Social: ❒ Never or rarely ❒ Sometimes ❒ Often ❒ Always

Work: ❒ Never or rarely ❒ Sometimes ❒ Often ❒ Always

How often do you get the social and emotional support you need:

❒ Always ❒ Usually ❒ Sometimes ❒ Rarely ❒ Never

In the past 7 days, how much pain have you felt?

❒ None ❒ Some ❒ A lot

In general, would you say your health is

❒ Excellent ❒ Very good ❒ Good ❒ Fair ❒ Poor

In general, would you say your dental health is

❒ Excellent ❒ Very good ❒ Good ❒ Fair ❒ Poor

On average, how many hours of sleep do you get per night?	Hours

Do you snore or has anyone told you that you snore?

❒ Yes ❒ No

In the past 7 days, how often have you felt sleepy during the daytime?

❒ Always ❒ Usually ❒ Sometimes ❒ Rarely ❒ Never