



HUMAN RESOURCES DEPARTMENT – BENEFITS DIVISION

BIOMETRICS / HEALTH SCREENING VERIFICATION FORM

USED ONLY BY PHYSICIANS WHO DO NOT PARTICIPATE IN THE CIGNA NETWORK

Rev: 1 | Date: 10/08/2026 | Print Date: 10/08/2026

This form may be used only if the biometric screening is completed by a personal physician who does not participate in the Cigna network. If verification is for a spouse, or domestic partner, please be sure to also print the name of the spouse/domestic partner. Please complete a separate form for each person screened.

Date

Print Employee Name (First, Last)

If applicable, Print Name of Spouse/Domestic Partner (First, Last)

I hereby confirm that _____ was assessed
for Cholesterol, Blood Pressure, Glucose, Body Mass Index and Body fat on ____/____/____.
He/she is or will be made aware of the test results.

Print Name of Health Screener

Signature of Health Screener

Telephone Number

Fax Number

Please affix the provider's official stamp on this completed document prior to submission.

Please mail to:
City of Fort Lauderdale
Attn: Benefits Division
401 SE 21st St.
Fort Lauderdale, FL 33316

OR:
Please fax this completed form to: 954-828-5328