

Ephrata National Bank 2025 Wellness Lab Voucher

Submitter: Ephrata National Bank Wellness	Date Range: Jan 1, 2025 – Nov 30, 2025	Requisition # (lab staff only):
Ordering Provider: Debra Bell, MD		

PARTICIPANT SECTION:

Step 1: Fill out the following (Please Print):

First Name:	Middle Initial:	Last Name:
Date of Birth: ____ / ____ / ____ M D YEAR	Last 4 digits of SS #: ____ _	Gender (please check): ☐ Female ☐ Male ☐ Non-binary / X
Have you been fasting (water only) for 8 – 12 hours? ☐ Yes ☐ No	Did you fill out and sign the back of this form? ☐ Yes ☐ No	

Step 2: Take this form along with valid photo ID to any of the following:

- Outpatient WellSpan Health Lab: [Click Here for Lab Locations and Hours](#) or visit www.wellspan.org
Please choose nonhospital-based lab locations from the website only.
- NEW! Two WellSpan Occupational Health Locations will service your wellness screening:
250 E Market St 2nd Floor, York, PA 17402 **OR** 1610 Orchard Dr. Chambersburg, PA 17201

THE FOLLOWING SECTION IS FOR LAB PERSONNEL ONLY:

CHECK FOR VALID PHOTO ID

1. Record the participant's Height, Weight, and Blood Pressure:

Height: _____ (in.) Weight: _____ (lbs.) Blood Pressure: _____ / _____

2. Requisition Entry

3. Submitter = Employer Group Wellness

4. Search for and select your patient

5. Record the Requisition number on the top of the form

6. Enter name of Employer Group

7. Order ALL tests listed in the box 

8. Click question mark or hit F11 (Order Details) to answer questions

9. Create and Receive specimen

10. Enter in collection information

11. Click Accept button

12. Scan double-sided Wellness form into EPIC

13. Tubes get sent to lab as normal for testing

Evidence Based Wellness Screen:

Hemoglobin A1C (LAB90)

AND

ONE of the following:

☐ Random (LAB9293)

☐ Fasting (LAB9292)

REVISED: 12/22 AW

LAB: Please scan into EPIC along with the lab voucher form

CONFIDENTIAL
Wellness Screening Consent Form
(Please Print Legibly)

First Name: _____ **Email:** _____

Last Name: _____ **Phone Number:** _____

Address: _____ **Ordering Physician: Debra Bell, MD**

CONSENT AND RELEASE STATEMENT (Signature required)

I hereby release the laboratory, its directors, employees and affiliates from any/all liability arising from, or in any way connected with, drawing blood /collecting biometric screening values for my clinical screenings or from the data derived there from.

I understand that:

1. One or more tubes of blood will be drawn.
2. The results from the biometric screening are considered a screening and are not to be a substitute for a physician office visit or specific diagnosis.
3. **The responsibility for sharing results with my family physician or following up and seeking additional medical advice and treatment for any health-related concerns is mine and not that of the organization associated with the screening.**
4. I authorize release of my clinical lab results, including Medical Record Number and demographic information, as follows:
 - a. To be posted under my personal MyWellSpan account
 - b. To be sent to WellSpan's ordering physician for review
 - c. To be shared between medical-related entities, if applicable

LIABILITY DISCLAIMER: Your participation is completely voluntary. If you currently have a medical condition, you are solely responsible for seeking any necessary medical consultation and/or approval prior to your participation in any physical activity. WellSpan and your employer assume no liability for any medical or professional issues resulting from your participation with WellSpan Wellness Services. You may provide WellSpan with certain information regarding family history of certain health conditions when completing information related to a wellness challenge, health coaching, screening, online program or wellness activity. To the extent that you provide such information, you agree that you are providing such information knowingly and voluntarily. WellSpan will maintain the confidentiality of such information in accordance with all applicable laws, including HIPAA and the Genetic Information Nondiscrimination Act of 2008. By participating in this wellness activity, you are providing your acknowledgement and consent regarding the aforementioned conditions.

Participant Signature: _____ **Date:** _____