The Salvation Army
Officer Wellness Program

Application Form

I am requesting participation in the Officer Wellness Program (OWP):

Name: _____ Rank: _____

Appointment: _____

Address: _____ Phone #: _____

_____

Office Phone #: _____

Cell Phone #: _____

Step One:

- Take these forms (including Application page, Wellness Plan page, and Physical Exam pages) to your local MD. Have health professional complete these forms after your examination.

Step Two:

- Establish an accountability relationship with an individual of your choice who will hold you accountable to your goals and action plan.
- My accountability partner will be: _____
- Submit forms to Dawn C. Smith, Officer Wellness Program Director at 180 E. Ocean Blvd, 12th Floor, Long Beach, CA 90802 or fax to: (562) 491-8640, or email to dawn.carolyn.smith@usw.salvationarmy.org

Step Three:

- After you receive approval to be enrolled in the OWP you may begin your OWP Program and then request reimbursement from Chesterfield Resources.
- Submit 6 and 12 month re-assessment reports to the Officer Wellness Program Director. If continuation in program is desired include request in 12 month report.

Continuation in the OWP as well as reimbursement for OWP expenses will be dependent upon submission of 6 & 12 month progress reports which show progress made. Reimbursements for expenses through Chesterfield Resources will require proper documentation/receipts.

I will be seeking reimbursement for the following program option (agreed upon with my physician) up to the maximum amount of $650.00

_____

(Example: Weight Watchers, Curves, YMCA/YWCA, 24 hr. Fitness, etc)

I wish to participate in the Western Territory Officer Wellness Program. I understand that I am making a commitment to improve my over-all health and fitness and that I will comply with the program requirements as stated above.

If, for whatever reason, I decide not to continue participating in the OWP, I will notify the Officer Wellness Program Director at THQ.

Officer's Signature: _____ Date: _____

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Officer Wellness Program

Wellness Plan

Name: _____ Date: _____

Date of Birth: _____ Age: _____

This Wellness Plan has been prepared in cooperation with:

Name: _____ Title (MD, etc): _____
(Name of physician completing this form)

Office Address: _____

Office Phone: _____

Diagnoses/Health Risks (*Physician to complete*):

_____ _____

_____ _____

_____ _____

Lab Test Results:	**Current**	**Goal**
1. Blood Pressure	_____	_____
2. Weight	_____	_____
3. Body Mass Index	_____	_____
4. Blood Glucose	_____	_____
5. Cholesterol Levels:		
Total Cholesterol:	_____	_____
HDL:	_____	_____
LDL:	_____	_____
TRIG:	_____	_____

Personal 6 month goals (*officer to complete*):

Goals must be specific (example: lower systolic blood pressure by 10 points, lose 10 lbs, lower blood sugar and cholesterol by 15mg):

1.

2.

3.

Physical Exam

GENERAL HISTORY

Complaints □ No □ Yes ~ please explain.

_____
_____
_____

Present Illness _____
_____
_____
_____

FAMILY HISTORY (Asthma, Cancer, Diabetes, other)

Mother _____

Father _____

Siblings _____

Children _____

PREVIOUS HISTORY (Diagnosis, date or age, hospital and/or doctor)]

Childhood _____

Medical _____

Surgical _____

Traumatic _____

MEDICATION

Medical Condition	Medication

TESTING

As part of, or in addition to your routine exam, please conduct the following tests as applicable:

* Test	Result	Details if Abnormal
Fecal Occult Blood		
Papanicolaou Smear		
Mammography (40 & over)		
Lipid Profile		
Colonoscopy		
Thyroid Function		
Serum Prostate-Specific Antigen – (40 & over)		
Dipstick Urinalysis		
PPD		
CBC/Comprehensive Metabolic Profile		
Electrocardiogram (If Applicable)		
Treadmill Stress (If Applicable)		

*** Please attach results of laboratory testing.**

HEALTH RISK ASSESSMENT

❖ Alcoholism or Substance Abuse	☐ Yes	☐ No
❖ Cancer	☐ Yes	☐ No
❖ Heart Disease	☐ Yes	☐ No
❖ Diabetes or other Metabolic Disease	☐ Yes	☐ No
❖ Pulmonary Disease	☐ Yes	☐ No
❖ HIV/AIDS or other STD	☐ Yes	☐ No
❖ Osteoporosis	☐ Yes	☐ No
❖ Thyroid or other Endocrine Disorder	☐ Yes	☐ No
❖ Stress Related Illness	☐ Yes	☐ No

REVIEW WITH PHYSICIAN ~ GOALS & PROGRAM OPTIONS

☐ Hospital/Medical Center Wellness Program

☐ Wellness Program/Family Membership YMCA/YWCA

☐ Weight Watchers/Similar Diet Program

☐ Health Club

☐ Local Gym/Curves

☐ Walking Program

☐ Water Aerobics

☐ Personal Equipment
e.g. treadmill, etc.
(in consultation w/physician)

_____ _____

Physicians Signature **Date**

*Please note that if you purchase home exercise equipment, a service plan fee is not covered. A delivery fee would be reimbursable from your OWP allowance.