



Please complete form for each adult Medi-Share 2.0 Participant in the household, except for adult children (age 18-22).

Applicant Name: _____ CCM ID Number: _____

Phone Number: _____ Email: _____

****Measurements must be taken and submitted within 90 days of HbA1c test****

These measurements must be taken and entered by a credentialed health professional (Doctor, RN, RD, Chiropractor, Emergency Medical Service Personnel, or Fitness Professional — *not an immediate family member*).

Note - This application will not be processed without waist measurement verification. (Take a tape measure with you, if necessary.)

Height (without shoes): _____ inches

Weight (without shoes): _____ pounds

Estimated weight of clothing during weighing: _____ pounds

Waist Measurement (at umbilicus; abdomen relaxed) _____ inches

I have personally documented the entries for the above-named person, and to the best of my knowledge, the numbers I have entered are accurate.

Signature of Authorized Person: _____

Name of Authorized Person (please print): _____

Title: _____ Agency: _____

Office Phone Number: _____ Date measurements were taken: ____ / ____ / ____

I affirm that all of the above entries are accurately reported by the authorized person.

Signature of Applicant: _____ Date: _____