**Diabetes Prevention Program Testing Event Request Form**

Due at least 45 days before a testing event. Questions?   
Contact [**wawellness@hca.wa.gov**](file:///\\hcafloly002\secured\Comm\Design\66%20Wellness,%20SmartHealth\66-030%20418%20Final%20DPP%20Onsite%20Request%20Form\wawellness@hca.wa.gov).

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Your organization:** | | | | | | | | | |
| **Date of request:** | | | | | | | | | |
| Your name (first & last): | | | | | | Email: | | | |
| Job title/role: | | | | | | Phone: | | | |
|  | | | | | | | |  | |
| **Testing events** | | | | | | | | | |
| **Testing event contact**  You  Someone else – *fill out below* | | | | | | | | | |
| Your name (first & last): | | | | | Email: | | | | |
| Job title/role: | | | | | Phone: | | | | |
| **Backup contact** (useful) | | | | | | | | | |
| Your name (first & last): | | | | Email: | | | | | |
| Job title/role: | | | | Phone: | | | | | |
|  | | | | | | | |  | |
| **Testing event planning** | | | | | | | | | |
| **How many testing events would you like to hold?** | | | | | | | | | |
| **Can non-employees attend?** (Such as PEBB-insured employees from other organizations.) | | | | | | | | | |
| **Yes** | **No** | | | | | | | | |
| **Is there anything else we need to know about your event?** Be specific. | | | | | | | | | |
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| **Details • Event** | | | | | | | | | |
| **Event title:** (title will be used for the online registration system. Example: OFM diabetes testing event.) | | | | | | | | | |
| **Estimate**: | | Eligible employees: | | | | | | Participants: | |
| **When:** | | Requested date: | | | | | Start time: | | End time: |
| **Where:** Location name:   (e.g., Room 200) | | | Address: | | | | | | |
| **Directions, parking, and/or landmark information:** How will testing providers find your location. | | | | | | | | | |

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| **Classes** | | | | | | | | |
| **Classes contact** | | | | | | | | |
| You | | Same as testing event contact | | | | | Someone else – *fill out below* | |
| **Backup contact** (useful) | | | | | | | | |
| Your name (first & last): | | | | | Email: | | | |
| Job title/role: | | | | | Phone: | | | |
| **Classes planning  Can non-employees attend?** (Such as PEBB-insured employees from other organizations.) | | | | | | | | |
| **Yes** | **No** | | | | | | | |
| **Room requirement checklist** Check 1 through 6 to confirm that each requirement will be met for all class series you hold. | | | | | | | | |
| 1. The same room is reserved for the same time each week (including 30 minutes before and after for setup and cleanup). | | | | | | | | |
| 1. The room is reserved for 20 consecutive weeks (16 for scheduled classes and 4 for any make-up sessions). | | | | | | | | |
| 1. The room reservation is under a generic name (like “Wellness Activity”) and does not contain the words “pre-diabetes”   or “diabetes” (Note: This is mandatory for HIPAA compliance). | | | | | | | | |
| 1. The room comfortably accommodates and seats 15 people. | | | | | | | | |
| 1. The room has a whiteboard or flip chart with markers | | | | | | | | |
| 1. There is space available in the room so participants can weigh-in discreetly | | | | | | | | |
|  | | | | | | | | |
| **Details • Class Series** | | | | | | | | |
| **When:** | | | Start date  To be held every: | | | Start time:  *Must last at least one hour*. | | End time: |
| **Where:** Location name:  (e.g., Room 200) | | | | Address: | | | | |
| **Directions, parking, and/or landmark information:** (Be specific for class coaches and call center staff.) | | | | | | | | |
| **Will there be any scheduling exceptions?** (Examples: room change on a specific date, class skipped due to holiday. Be specific.) | | | | | | | | |
| **To request more events or classes attach additional copies of this form.** | | | | | | | | |
| **What happens next?**  Send your completed form to [wawellness@hca.wa.gov](mailto:wawellness@hca.wa.gov). Washington Wellness will contact you about your request. | | | | | | | | |