**Diabetes Prevention Program Testing Event Request Form**

Due at least 45 days before a testing event. Questions?
Contact [**wawellness@hca.wa.gov**](file:///%5C%5Chcafloly002%5Csecured%5CComm%5CDesign%5C66%20Wellness%2C%20SmartHealth%5C66-030%20418%20Final%20DPP%20Onsite%20Request%20Form%5Cwawellness%40hca.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:  |
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| **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).
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| 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).
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| 1. [ ]  The room comfortably accommodates and seats 15 people.
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| 1. [ ]  The room has a whiteboard or flip chart with markers
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| 1. [ ]  There is space available in the room so participants can weigh-in discreetly
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| **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. Washington Wellness will contact you about your request. |