2016 FLU CLINIC REGISTRATION

Client Name: ____

Address: ____

City/State: ____

Phone: ______________________ **Fax:** ______________________

Contact : ______________________ **Title:** ______________________

email: ____

2nd CONTACT NAME : ____________________ **Phone:** ____________________

Projections for your 2016 Clinic: **# vaccines**

		# vaccines
Influenza vaccinations - 6 months & up	$25.00	
Pneumonia vaccinations (over 18)	$100.00	
TDaP vaccinations - (Tetanus, Diphtheria, Pertussis)	$65.00	

Days of the week you prefer: M T W Th F Sa Su Time of day you prefer: ______________

PAYMENT METHOD: (check one)

_____Bill company for employee flu vaccines only – nurse collects for all others.

_____Bill company for all vaccines.

_____Bill insurance for all vaccines.

_____Nurse collects cash or check for all vaccines.

______________________________________ ______________

Contact person signature Date

Please email or fax this form to 303-374-8656 at your earliest convenience

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