

Health Promotion Affiliates Flu Request Form

Today's Date: _____

Company: _____

3 Optional Dates: _____ **Time Requested:** _____

Address: _____ **Site Phone:** _____

_____ **Fax:** _____

Site Contact: _____ **E-mail:** _____

Estimate the numbers of hours you need for your clinic based on 20 shots per hour.

Please attach written directions with this fax. It saves us valuable time.

How many flu shots do you expect at your clinic? _____

We need a very accurate count and will bring only that amount.

Please call 10 working days before the clinic to confirm the final count of flu shots.

Payment/Billing Information: Cost Center: _____

A. Invoice for the balance of the flu clinic.

B. If employees pay, the company will collect the fee.

Billing Information: Company: _____

Name: _____

Address: _____

Please note: reimbursement for mileage is charged at the Federal Reimbursement rate. If the mileage is greater than 100 miles round trip, travel time will be charged at \$50/hour. If between 150-199 round trip, \$75.00. If over 200 miles round trip, \$100.00

For Office Use:

Please send this completed form with check to: Note: Change of address.

*Att. Health Promotion Affiliates, 56 Kearney Rd., Needham, MA 02494
Phone: (781) 449-2233 Fax:: (781) 449-7045 E-mail: mca.hpa@verizon.net*

**72 hours notice required for cancellation to avoid charges for a scheduled event.
2 hour minimum for all screenings.**