



**FLU CLINIC REGISTRATION**

Client Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Title: \_\_\_\_\_

e-mail: \_\_\_\_\_

Total # of employees: \_\_\_\_\_

Influenza vaccinations Projected: \_\_\_\_\_

Pneumonia vaccinations Projected: \_\_\_\_\_

Tetanus vaccinations Projected: \_\_\_\_\_

Preferred day(s) of the week: (select one): M T W Th F Sa Su

Preferred hour of the day for your clinic: \_\_\_\_\_

**PAYMENT METHOD:** (check one)

\_\_\_\_\_ Bill company for employee flu vaccines only – nurse collects for all others.

\_\_\_\_\_ Nurse collects cash or check for all vaccines.

\_\_\_\_\_ contact person signature and title \_\_\_\_\_ date

PLEASE FAX TO **303-374-8656** or e-mail to [info@milehiimmunizations.com](mailto:info@milehiimmunizations.com)  
and we will schedule your clinic for this fall.