



2009 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
and we will schedule your clinic for this fall.