

# EMPLOYER SERVICE REQUEST FORM

*\*Instructions to employers\**

*Please complete all required fields*

*Send this form via fax to 719-527-1749 Attn: Dianne Groves, Office Manager*

## INFLUENZA (FLU) VACCINATIONS

Company: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

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

Authorized Company Contact: \_\_\_\_\_

Service Request: \_\_\_\_\_

Number of employees requiring vaccination: \_\_\_\_\_

**Do you request an employee vaccination clinic at your company location?**

(Must have a minimum of 20 employees confirmed)

**YES**

**NO**

**Please provide tentative dates and times for your request.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**Signature of Company Contact**

\_\_\_\_\_  
**Date**

*Thank you for your employee vaccination request, our medical clinic will contact you upon review of the completed request form. We look forward to assisting you and your employees!*

*If you have any questions, please do not hesitate to contact Dianne Groves, Office Manager at 719-527-1728 or via email at [dgroves@broadmoormedical.com](mailto:dgroves@broadmoormedical.com).*

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