TrustCare Health Employer Services

On-Site Event Agreement

onsiteevents@trustcarehealth.com

Company ____

Requested Date and Time ____

Alternate Date and Time ____

Address ____

Company Contact ___________________________________ Phone _____________________________

Email ____

Will services be filed under Insurance? Yes / No Name of Insurance _______________________

A copy of the employee's insurance card and driver's license will be required

Will employer like to be billed for service? Yes / No

Billing Contact _______________________________________ Phone ____________________________

Email ____

- ☐ Drug Screening/Rapid 10-panel
- ☐ Blood Testing - Test requested __________________________________
- ☐ DOT/Non-DOT Physicals
- ☐ Flu Shots
- ☐ Vaccinations ____
- ☐ Other ____

Number of employees participating _______ (Minimum of 10 participants required to avoid $50 service fee unless approved by TrustCare representative prior to event) Must give 48-hour notice prior to cancelling on-site service.

You will be contacted by TrustCare to confirm the requested services and date.

Signature ____ Date ______________

Feel Better Faster™