TrustCare Health Employer Services

# Clinical On-Site Event Agreement

onsiteevents@trustcarehealth.com

Company _____

Address _____

Company Contact _____ Phone _____

Email _____ Inside/Outside _____

Requested Date/Time _____ Alternate Date/Time _____

Services filed to Insurance Yes / No Name of Insurance _____

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

Employer billed for service / onsite payment Billing Contact _____
Phone _____ Email _____

Services Requested _____

Additional Requests _____

Number of employees participating _____. If your total number to show is less than 85% of the number of participants given, there will be a $25 charge per person. Additionally, there is a $100/hour fee for any time over the requested time frame. Must give a 48-hour notice prior to cancelling on-site service.

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

Signature _____ Date _____

For Internal Use Only

Staff On-Site Lead Contact _____

Testing Type/Amount _____

Equipment Required _____

Staff Type/Amount _____

Travel Info _____

Total Participants _____ Invoice Total _____