BHA

BUSINESS *HEALTH* AFFILIATES

Your Employer's Corporate Name:____

Your Manager's Name: ____

Corporate Address at which you work:

Street # and name____

____

City, State, Zip____

Your Name: ____

Company ID # ____

Home Address:

Street # and name____

____

City, State, Zip____

Work Phone: ____

Home Phone: ____

Email Address: ____

Location, or provider, where you obtained your flu vaccination:

____

Please return this form, and a copy of your receipt, via fax to 800-856-1434.

Or email them both to info@businesshealthaffiliates.com

3212 Jefferson #197, Napa California | phone 707-256-3456 facsimile 800-856-1434