# HEALTH DIRECT
## INSTITUTIONAL PHARMACY SERVICES

600 Blair Park, Suite 195
Williston, VT 05495
Phone: (800) 861-1903 Fax (800) 861-1904

## EMPLOYEE FACE SHEET FOR COVID IMMUNIZATION

Please complete this form in its entirety OR provide the following information in your own format. Please return this form to the pharmacy ASAP. Faxing the information would be the preferred method. Thank you.

FACILITY NAME: BRATTLEBORO MUTUAL AID - DBA: THOMPSON HOUSE NURSING HOME

### EMPLOYEE Information

EMPLOYEE Name: _____

Address: _____

Town, State, Zip code: _____

Phone number: _____

Date of Birth: _____ Social Security Number: _____

Drug Allergies: _____

For **Prescription Drug Insurance information**, please **attach a photocopy** of the front and back of the **insurance card** if possible or fill out the information below.

### Billing Information

**Prescription** Drug Insurance Company: _____ ID# _____

Group #: _____ Bin#:_____

PCN#:_____ Phone #: _____

Primary Cardholder: Yes or No (circle)

If no, provide primary cardholder name & date of birth _____