

BLUE CROSS OF JAMAICA WELLNESS SERVICES UNIT

APPLICATION FOR HEALTH SCREENING SERVICES

Request made by.....
 Name of Company/Service Club/Provider/Community Group
 Name of Contact Person.....Tel:Fax:.....
 Date(s) Required.....Start/End Time.....
 Type of Event.....
 Address of Venue (give details e.g. landmarks)

Please state road condition on the way to venue/adequate parking for large mobile unit (takes up three car spaces)

Venue Tel:Venue Fax:
 No.of Participants Expected
 Age Range of Participants
 Category (children, adult, staff, public)
 Name of Blue Cross Representative
 Signature of Applicant
 Date of Request

Kindly fill out this section to indicate how payments will be made to Blue Cross of Jamaica.

Details of Payment

SERVICES	PAID BY APPLICANT	CLIENTS (Place tick under appropriate section)
Height/Weight	_____	_____
Blood Pressure	_____	_____
Vision	_____	_____
Hearing	_____	_____
B/Sugar	_____	_____
B/Cholesterol	_____	_____
ECG	_____	_____
Flat Rate	_____	_____
Health Talk	_____	_____

OTHER ARRANGEMENTS

