



Corporate Care Agreement

Date: _____

(Contact Name)

(Company Name)

(Phone Number)

Thank you for choosing Olmsted Medical Center's *Corporate Care* program to provide on-site healthcare services for your employees. We ask that you please read through the following items and indicate your agreement by signing this form and returning it to the fax number or email address listed below as soon as possible.

Event Date: _____ Time: _____

Services Requested:	Cost:
_____	_____
_____	_____
_____	_____
_____	_____
Total Per Each Participant:	
Any Additional Fees (as stated below):	

- \$200 on-site fee
- If outside Olmsted Medical Center's coverage area, a \$300 on-site/travel fee applies (OMC's coverage area includes Rochester and OMC's branch clinic locations.)
- One-hour time slots for companies with less than 100 employees receiving these services; if more time is requested, there will be a \$100 charge for the second hour and \$50 charge per hour after that, plus the cost of the service per person.
- OMC staff cannot collect cash or individual insurance information.
- OMC will bill your company directly on one statement for the total service.

As the designated representative for _____ business, I understand and agree with the above information regarding the services requested and the pricing for each participant. I understand that, by not returning this form with my signature prior to the Event Date, the agreement with OMC to provide the indicated services may be canceled.

Signature: _____ Printed Name: _____ Date: _____

Return signed form by fax or email to:
Olmsted Medical Center
Occupational Health Services
Attention: Corporate Care
210 Ninth Street SE
Rochester, MN 55904
Fax: 507.292.7001
Email: occhealth@olmmed.org

If you have questions, please call the Business Services team at 507.292.7144.