EduMed
HEART AND HEALTHCARE
MEDICAL CENTRE

OCCUPATIONAL HEALTH & EMPLOYEE MEDICALS
CORPORATE BOOKING FORM

FAST • AFFORDABLE • PROFESSIONAL

CLIENT DETAILS

Company Name: _____
Contact Person: _____
Designation: _____
Telephone: _____
Cell: _____
Email: medicals@edumedsa.co.za _____

Physical Address:
_____
_____
_____

Company Registration No.: _____
VAT No (if applicable): _____

BOOKING DETAILS

Preferred Medical Date: ____/____/____ Preferred Time: _____

Medical Venue (Tick One)

- ☐ EduMed Medical Centre
- ☐ On-Site Medicals at Company Premises

Company Site Address (if applicable)
_____
_____
_____

PACKAGE REQUIRED (Tick One)

☐	**BRONZE PACKAGE R499**	Ideal for Pre-Employment Medicals and Low-Risk Work Environments
☐	**SILVER PACKAGE R799**	Enhanced Occupational Medical Assessment — MOST POPULAR
☐	**GOLD PACKAGE R1,099**	Comprehensive Occupational Health Assessment
☐	**PLATINUM PACKAGE R1,499**	Executive & High-Risk Occupational Medical Assessment

NUMBER OF EMPLOYEES

Total Employees to be Booked: _____ Employees

SPECIALISED MEDICALS REQUIRED (Tick all that apply)

- ☐ Driver Medicals
- ☐ Working at Heights Medicals
- ☐ Confined Space Medicals
- ☐ Executive Medicals
- ☐ Pre-Employment Medicals
- ☐ Periodical Medicals
- ☐ Exit Medicals

INDIVIDUAL TESTS REQUIRED (Tick all that apply)

- ☐ Drug Screening
- ☐ Audiometry (Hearing Test)
- ☐ Spirometry (Lung Function Test)
- ☐ ECG (Heart Screening)
- ☐ Vision Screening
- ☐ Blood Pressure Assessment
- ☐ BMI Assessment
- ☐ Alcohol Testing
- ☐ Urinalysis
- ☐ Occupational Health Risk Assessment

EMPLOYEE BREAKDOWN

Department	No. of Employees
Administration	
Production	
Warehouse	
Drivers	
Security	
Supervisors	
Management	
Other	
TOTAL EMPLOYEES	

SPECIAL REQUIREMENTS / NOTES

_____
_____

DECLARATION

I confirm that the above information is correct and request EduMed Heart and Healthcare Medical Centre to schedule occupational medical assessments for the employees listed. I understand that bookings are subject to availability and that confirmed bookings may be subject to EduMed's Terms and Conditions.

AUTHORISED COMPANY REPRESENTATIVE

Name: _____
Position: _____
Signature: _____ Date: ____/____/____
Company Stamp:

EDUMED OFFICE USE ONLY

Booking Reference: _____
Booking Confirmed By: _____
Medical Date: ____/____/____

Invoice Number: _____
Payment Status:
☐ Paid ☐ Pending ☐ Account