



MEDKEY
Healthy Discounts Program

Letter of Agreement

As a participating business in the *MedKey Healthy Discount Program*, I agree to provide the specified discount on the items or services listed below to customers presenting a Davis Regional Medical Center *MedKey card* at the time of purchase.

Name of Business: _____

Business Address: _____

Phone Number: _____ Fax Number: _____

Amount of Discount: _____

Item to be Discounted: _____

Davis Regional Medical Center agrees to publish the name and location of the Company to *MedKey* cardholders along with the discount offered.

This agreement may be terminated by either party, with or without cause, upon thirty (30) days notice via mail, email or facsimile. This agreement may not be amended except in writing when signed by both parties.

Company Representative Name (*Please Print*): _____

Signature: _____ Date: _____

Title: _____

DRMC Representative _____ Date: _____

Please keep a copy of this form for your records and mail or fax the original to:

Janie Stikeleather, Director of Marketing & Public Relations
Davis Regional Medical Center
PO Box 1823
Statesville, NC 28687
(704) 838-7106
Fax: (704) 838-7111
janie.stikeleather@drmc.hma-corp.com