



NEW FACILITY REGISTRATION FORM

Please complete registration form, and fax to (866) 988-4887 or email to services@cogentmedlab.com

FACILITY INFORMATION

FACILITY NAME		CORPORATE AFFILIATION
STREET ADDRESS/SUITE NUMBER		CITY/STATE/ZIP
PHONE NUMBER	FAX NUMBER	
REQUESTED START DATE	INITIAL # OF COVID KITS REQUESTED:	ESTIMATED MONTHLY COVID KITS:

FACILITY CONTACT

NAME & TITLE	PHONE #	EMAIL
NAME & TITLE	PHONE #	EMAIL
NAME & TITLE	PHONE #	EMAIL
NAME & TITLE	PHONE #	EMAIL
NAME & TITLE	PHONE #	EMAIL

CRITICAL LAB RESULTS REPORTING CONTACTS - *Additional space provided on next page for more Providers if needed.*

PROVIDER NAME	CONTACT NAME	PHONE #
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*NOTE: If only one phone number for Facility, only provide one phone number.

CRITICAL LAB RESULTS REPORTING CONTACTS - *Continued from PAGE 1*

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