NEW YORK STATE DEPARTMENT OF HEALTH
WADSWORTH CENTER
CLINICAL LABORATORY EVALUATION PROGRAM

SINGLE USE PERMIT INITIAL REQUEST FORM

Fax completed form to: 518-449-6917

TESTING LABORATORY INFORMATION

CLIA Number:

Name of Laboratory:

Address:

City: State: Zip:

Lab Phone Number:_____Lab Fax number:

Contact Person Name:

Contact Person Email:

Laboratory Director Name:

Laboratory Director Email:

TEST INFORMATION

Test Name:

Unique Test Identifier (required):

Specimen Type: Specimen Collection Date:

PATIENT INFORMATION

Patient First Name: Patient Last Name:

Second Patient Identifier (DOB or EMR#):

Patient Symptoms: