SMA SPECIALTY MEDICAL LAB

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940 Pennsylvania Blvd., Unit A, Feasterville, PA 19053
Phone: (954) 306-3667 Fax: (954) 306-3157
4101 N Hospital Dr, Suite 102, Plantation, FL 33317
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NEW PHYSICIAN ENROLLMENT FORM

PHYSICIAN PRACTICE

Practice Name: ______________________

Street Address: ______________________

City: ____________ State: ________ Zip: ________

Phone: ______________ Fax: ______________

After Hours Phone: ______________

☐ Physicians Office ☐ Nursing Home (NH) ☐ Assisted Living Facility (ALF) ☐ Treatment Facility (TF)

CONTACT INFORMATION (responsible for specimens on Physician's behalf)

Contact Name: ______________________

Phone: ______________ Email: ______________

Preferred Results Delivery Method: ☐ Website Self Retrieval ☐ Fax ☐ Email

SPECIMEN INFORMATION

Specimen	
☐ BLOOD	ESTIMATED WEEKLY SPECIMENS:
☐ TOXICOLOGY	ESTIMATED WEEKLY SPECIMENS:
☐ COGNITIVE PROGRAM	ESTIMATED WEEKLY SPECIMENS:
☐ PGX	ESTIMATED WEEKLY SPECIMENS:
☐ RPP ☐ GPP ☐ UTI	ESTIMATED WEEKLY SPECIMENS:
☐ WOUND PCR ☐ NAILS PCR	ESTIMATED WEEKLY SPECIMENS:
☐ PATHOLOGY	ESTIMATED WEEKLY SPECIMENS:
☐ SARS-COV-2, PCR ☐ COVID19 - IgG/IgM	ESTIMATED WEEKLY SPECIMENS:

Pick up by:

☐ Fedex ☐ UPS ☐ Courier

HOURS OF OPERATION & SPECIMEN COLLECTION TIME

DAYS	OFFICE HOURS	SPECIMEN COLLECTION TIME
MONDAY		
TUESDAY		
WEDNESDAY		
THURSDAY		
FRIDAY		
SATURDAY		
SUNDAY		

Each of the Ordering Providers hereby acknowledges and agrees by their signatures on this Enrollment Form, that: (i) he/she agrees to the use of his/her signature for electronic signature purposes within any EMR / LIS portal and (ii) he/she agrees the use of his/her electronic signature as the legal equivalent of his/her manual/hand-written signature and each consents to be legally bound. SMA agrees to maintain copies of all records containing electronic signatures as legally required.

ORDERING PROVIDERS :

Physician's Name: ______________________

Credentials: ☐ MD ☐ DO ☐ NP ☐ ARNP ☐ APRN ☐ CNP ☐ PA

Individual NPI ______________________

I hereby consent to the use of my signature for electronic signature purposes within any EMR / LIS portal.

PHYSICIAN SIGNATURE **(please sign inside this box with black ink)**	DATE SIGNED

Physician's Name: ______________________

Credentials: ☐ MD ☐ DO ☐ NP ☐ ARNP ☐ APRN ☐ CNP ☐ PA

Individual NPI ______________________

I hereby consent to the use of my signature for electronic signature purposes within any EMR / LIS portal.

PHYSICIAN SIGNATURE **(please sign inside this box with black ink)**	DATE SIGNED

Physician's Name: ______________________

Credentials: ☐ MD ☐ DO ☐ NP ☐ ARNP ☐ APRN ☐ CNP ☐ PA

Individual NPI ______________________

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PHYSICIAN SIGNATURE **(please sign inside this box with black ink)**	DATE SIGNED

Physician's Name: ______________________

Credentials: ☐ MD ☐ DO ☐ NP ☐ ARNP ☐ APRN ☐ CNP ☐ PA

Individual NPI ______________________

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PHYSICIAN SIGNATURE **(please sign inside this box with black ink)**	DATE SIGNED

Physician's Name: ______________________

Credentials: ☐ MD ☐ DO ☐ NP ☐ ARNP ☐ APRN ☐ CNP ☐ PA

Individual NPI ______________________

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PHYSICIAN SIGNATURE **(please sign inside this box with black ink)**	DATE SIGNED

SALES EXECUTIVE ______________________
(please print full name)