



Toll Free: (877) 697-6252 Fax: (888) 322-9524 Phone: (954) 306-3667 Fax: (954) 306-3157
 940 Pennsylvania Blvd., Unit A, Feasterville, PA 19053 4101 N Hospital Dr, Suite 102, Plantation, FL 33317
 www.smalaboratory.com

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

<input type="checkbox"/> BLOOD	ESTIMATED WEEKLY SPECIMENS:	<input type="text"/>
<input type="checkbox"/> TOXICOLOGY	ESTIMATED WEEKLY SPECIMENS:	<input type="text"/>
<input type="checkbox"/> COGNITIVE PROGRAM	ESTIMATED WEEKLY SPECIMENS:	<input type="text"/>
<input type="checkbox"/> PGX	ESTIMATED WEEKLY SPECIMENS:	<input type="text"/>
<input type="checkbox"/> RPP <input type="checkbox"/> GPP <input type="checkbox"/> UTI	ESTIMATED WEEKLY SPECIMENS:	<input type="text"/>
<input type="checkbox"/> WOUND PCR <input type="checkbox"/> NAILS PCR	ESTIMATED WEEKLY SPECIMENS:	<input type="text"/>
<input type="checkbox"/> PATHOLOGY	ESTIMATED WEEKLY SPECIMENS:	<input type="text"/>
<input type="checkbox"/> SARS-COV-2, PCR	ESTIMATED WEEKLY SPECIMENS:	<input type="text"/>

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
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