



LAB ENROLLMENT FORM
Every field **MUST** be completed

Clinic/Practice Information

Clinic/Practice Name: _____

Address: _____

Phone Number: _____ Fax Number: _____

Physician Information

(1) Full Name: _____

NPI: _____ DEA: _____ LICENSE: _____

(2) Full Name: _____

NPI: _____ DEA: _____ LICENSE: _____

Point of Contact

Name: _____

Email: _____ Phone Number: _____

LabNexus Login Information (Reporting):

Username: _____ Password: _____

Backup Reporting Option: RECEIVE RESULTS via FAX or EMAIL: _____

Supplies Needed:

Start Date: _____

Toxicology :

Supplies: Regular Cups: _____ Point of Care Cups: _____ Oral Swabs: _____

Blood: *Must send copy of physician's current requisition form.*

DNA

Wound Care

Specimen Collector/Phlebotomist Information:

Name: _____

Email: _____ Phone Number: _____

Additional information on second page must be completed in order to employ collector/phlebotomist.

Representative Information

Name: _____

Email: _____ Phone Number: _____

Upon completion e-mail this form to info@mmbstrategy.com



Specimen Collector/Phlebotomist Information

All Collector/Phlebotomist MUST be approved by management before being hired.

Collectors Name: _____ Phone #: _____

Email Address: _____

Start Date: _____

Toxicology (Collector)

Blood (Phlebotomist)

Physician's Office: _____

Days will be working: _____

Estimated volume per month: _____

Current Hourly Rate: _____