COVID-19 TESTING FACILITY

FACILITY INFORMATION

Facility name: _____

Address: _____

City: _____ Postal code: _____

Phone number: _____

Projected date of facility opening: _____

CONTACT INFORMATION FOR ACCREDITATION ACTIVITIES

Name: _____ Title: _____

Address: _____

City: _____ Postal code: _____

Phone number: _____ Email: _____

ORGANIZATIONAL LEADERSHIP

Complete the leadership appropriate for the organization.

Medical leadership	First name	Last name	Title	Email
Facility medical director (must be College registrant)				
Alternate medical director				
Other leadership				
Other leadership				

PERSONNEL (Check all that apply)

- ☐ Medical doctor (MD)
- ☐ Medical lab assistants
- ☐ Medical lab technologists
- ☐ Medical office assistants
- ☐ Nurse practitioner (NP)
- ☐ Registered nurse (RN)
- ☐ Licensed practical nurse (LPN)
- ☐ AsllowpP3aivef 8 0 0 8 54 3.648 659.9 Tm49Me57sedt07 59Dnr0 10 10 55 54 59.76g 1 i /TT0 1 Tf 10 0 0 10 74.648 659.9 T44 -/