WSLH Proficiency Testing

www.wslhpt.org

2601 Agriculture Drive, Madison, WI 53718 • (800) 462-5261 • FAX (608) 265-1111

New Customer Proficiency Testing Enrollment Form

Today's Date: _____ **This request is for enrollment year:** _____

Identification Information

WSLH PT ID# | | | | | | | |

Previous customer account ID if known.

CLIA ID# | | | **D** | | | | | | | |

☐ Check box if application in progress and CLIA ID# not yet received

Contact Information Of Person Completing This Form

Facility Name	**Contact Name**
Phone	**Email**

Select Type of Testing Site for this Order

◯ Clinic - large (>20 Physicians)	◯ Hospital - large (>350 beds)	◯ Physician Office Lab	◯ Stat/Urgent Care Lab
◯ Clinic - medium (6-10 Physicians)	◯ Hospital - medium (100-350 beds)	◯ Point of Care Testing	◯ Student Health Lab
◯ Clinic - small (<6 Physicians)	◯ Hospital - small (<100 beds)	◯ Public Health Lab	◯ Veterans Administration
◯ Federal (Prison/Military)	◯ Independent Clinical Lab	◯ Research & Development	◯ Veterinary
◯ Forensic Lab	◯ Manufacturer	◯ Satellite Lab	Other (please indicate below)
◯ Health Management Organization	◯ Nursing Home	◯ Screening, wellness, fitness	
◯ Home Health/Extended Care	◯ Pharmacy	◯ Specialty	

◯ Online/Website	◯ Email	◯ Advertisement	◯ Conference*
◯ Peer Recommendation*	◯ Agency Recommendation*	◯ Mailing	◯ Other*

***Please elaborate**

Demographic Information

Shipping Information

Facility Name		**Contact Name**	
Street Address		**Apt, Suite, Bldg. (optional)**	
City	**State/Province/Region**	**Postal/Zip Code**	**Country**
Phone	**Fax**	**Email**	

Billing Information Check here if same as shipping information ☐

Facility Name		**Contact Name**	
Street Address		**Apt, Suite, Bldg. (optional)**	
City	**State/Province/Region**	**Postal/Zip Code**	**Country**
Phone	**Fax**	**Email**	

Send Reports to Check here if same as shipping information ☐

Facility Name		**Contact Name**	
Street Address		**Apt, Suite, Bldg. (optional)**	
City	**State/Province/Region**	**Postal/Zip Code**	**Country**
Phone	Fax	**Email**	

Consultant Information (optional)

Facility Name		**Contact Name**	
Street Address		**Apt, Suite, Bldg. (optional)**	
City	**State/Province/Region**	**Postal/Zip Code**	**Country**
Phone	**Fax**	**Email**	

New Customer Proficiency Testing Enrollment Form - continued

Accreditation Information

List accreditation agency(ies) which monitor the testing done at this site (check box at right if application in progress and ID# not yet received)

Agency Name	ID Number	
Agency Name	ID Number	☐
Agency Name	ID Number	☐
Agency Name	ID Number	☐
Agency Name	ID Number	☐

All applicable scores will be sent to designated agencies by default unless specified below

Do NOT send the following scores to agencies:

Order Information

It will be necessary to refer to our current price list while completing this portion or please attach your quote to this form.

- Online Training and Competency, Assayed Samples Sets, AUDIT Linearity Products, and CEQAL Accuracy Monitoring have separate order forms.
- Only Quality Evaluation (QE) and Additional Sample products may be ordered in multiple quantities. All others indicate quantity of 1.
- Customers wanting to enroll only in certain events, please indicate so under Order Comments below. You will only be charged for events enrolled.

Product Name	Item#	Price	Quantity	Total Price
				$ 0.00
				$ 0.00
				$ 0.00
				$ 0.00
				$ 0.00
				$ 0.00
				$ 0.00
				$ 0.00
				$ 0.00
				$ 0.00
				$ 0.00
				$ 0.00
				$ 0.00
				$ 0.00
				$ 0.00
				$ 0.00
				$ 0.00
				$ 0.00
				$ 0.00
				$ 0.00
Order Comments	**Subtotal**			$ 0.00
	Binders (enter quantity) $15 (2021) or $18 (2022)			$ 0.00
	Annual processing fee $80 (2021) or $85 (2022)		1	$ 0.00
	Total			$ 0.00

Payment Information

Purchase Order (PO#) - optional		VISA/MC: If you wish to pay by credit card, please wait for your invoice for instructions.