CTLDNA
CLINICAL TESTING LABORATORIES INC.

New Account Enrollment Form

3655 Research Dr.
Genesis Center A
Las Cruces, NM 88003
Phone: 575-449-2736

LAB ASSIGNED ACCT#_____

Contract Sales Information

Company Name Focus Healthcare Services
Sales Representative/Account Executive _____
Address Line 1 3710 Greenway Street
City Austin State Texas ZIP 78705
Address Line 2 _____
Phone 512 364-9029 Fax 512 233-2327
Email Address(es) admin@focus-hcs.com

New Account Information

Facility Name _____ Physician Name _____ NPI _____
Address Line 1 _____ City _____ State _____ ZIP _____
Address Line 2 _____ Phone _____ Fax _____
Email Address(es) _____ RPI Role? YES _____ NO _____

Secondary Contact Information

Name _____ Phone _____ Fax _____
Email Address(es) _____

Office Contact Information

Name _____ Phone _____ Fax _____
Address Line 1 _____ City _____ State _____ ZIP _____
Address Line 2 _____ Email Address(es) _____

Results Release Designee

Name _____ Phone _____ Fax _____
Email Address(es) _____

Information for Contracts

Name of Authorized Signatory for Business
(President, Owner, CEO) _____ Business Name _____
Address Line 1 _____ City _____ State _____ ZIP _____
Address Line 2 _____ Phone _____ Fax _____
Email Address(es) _____

Kit Supply Shipment

To _____ Supplies Needed By _____ /_____ /_____
Address Line 1 _____ City _____ State _____ ZIP _____
Address Line 2 _____ Phone _____
Buccal Swab Kits Required _____ Return Shipping Supplies Required _____

PLEASE RETURN BY FAX AT: (512) 233-2327 **OR** **RETURN BY EMAIL AT: admin@focus-hcs.com**