

ACCOUNT SET-UP FORM

Client Name: _____

DUNS#	TAX ID#
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Employee Testing?: Yes No

Laboratory Contact Information

Preferred method of communication from laboratory problem resolution: Email: <input type="checkbox"/> Phone: <input type="checkbox"/>			
Primary Lab Contact:		Title:	
Main Address:	City:	State:	Zip:
Phone:	Fax:	Email:	
Main Fax Results:			
Secondary Lab Contact:		Title:	
Phone:		Email:	
Additional Email Address(es):			

Purchasing Information

Contact Name:		Title:	
Phone:	Fax:	Email:	
Purchase Order # Required:	<input type="checkbox"/> NO <input type="checkbox"/> YES	PO#:	

Accounts Payable Information

Contact Name:		Title:	
Phone:	Fax:	Email:	
Billing Address:	City:	State:	Zip:
Contact Name on Invoice:			
Invoice Submission Preference (please select one):		Mailed: <input type="checkbox"/>	Faxed: <input type="checkbox"/>
Email: <input type="checkbox"/>			
Affiliated with other hospitals or integrated health network?	<input type="checkbox"/> NO <input type="checkbox"/> YES	If Yes, please indicate other hospitals/integrated health network below: _____	

Eurofins Viracor Internal Use

Account Name: _____	Sales Territory: _____
Account Executive: _____	Acct. #: _____
Form Generated By (Internal Associate): _____	

It is necessary to have a one-time signature on file for all new clients. By signing below, the person as a representative of your organization agrees and guarantees payment. This form should be signed and faxed back to Eurofins Viracor before tests can be resulted.

Signature: _____ **Date:** _____