eurofins | Viracor

ACCOUNT SET-UP FORM

Client Name:

Laboratory Contact Information

Primary Lab Contact:		Title:	
Main Address:	City:	State:	Zip:
Phone:	Fax:	Email:	
Secondary Lab Contact:		Title:	
Phone:	Email:		

Lab Results

Please Send Lab Results By: Email: Fax:

Additional Email Address(es):

Retriever Portal: ☐ (complete attached Online Service Terms of Use Agreement)

Purchasing Information

Contact Name:		Title:
Phone:	Fax:	Email:
Purchase Order # (if required)		

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: ☐ Faxed: ☐

Emailed: ☐ (encrypted email) ☐ (unencrypted email, sign additional form attached, Authorization to Send Invoices Via Unencrypted Email)

Affiliated with other hospitals or integrated health network? ☐ Yes ☐ No

If Yes, please indicate other hospitals/integrated health network below:

Eurofins Viracor Internal Use

Client Name: _____ Account Number: _____

Area Sales Manager: _____ Sales Area : _____

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 emailed back to Eurofins Viracor before tests can be resulted.

Signature: _____ **Date:** _____

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