Pooled Testing Plan

For planning purposes please complete the attached spreadsheet with the volume of tests that you plan to send to the laboratory.

Name of Organization:

Administrative Contact Person:

Phone Number:

Email Address:

Bill Insurance for Reflex Testing: Yes ☐ No ☐

Will you be testing students/minors: Yes ☐ No ☐

Organizational Manager Access:

Please provide name(s) and email(s) of individuals at your organization who would need to have access to view child registration information.

Name:

Email:

Name:

Email:

Name:

Email:

Testing Schedule:

Start Date of Testing:

Total Volume of Tests Needed:

Date of Testing:	Date of Lab Delivery:	Time of Lab Delivery:	# of tests to be delivered:

* Samples should be received at the lab within 24 hours of saliva collection.