ACP Medical Laboratory Evaluation

PAID REPLACEMENT SPECIMEN ORDER FORM

(Fax completed form to 1-202-835-0440 or email to mle@acponline.org)

MLE ID NUMBER: _____

REQUEST DATE: _____ YOUR NAME: _____

YOUR FAX #: _____ YOUR PHONE #: _____

I would like to order the following specimen(s):

(Include prefix and number, for example, CH-1)

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

I agree to pay the fee of $15 per specimen, plus $50 for shipping and handling.

Signature: _____

Name of facility: _____

Method of payment:

❑ **Send Invoice** ❑ **Purchase Order** _____

Credit Card: ❑ **VISA** ❑ **Mastercard** **CVV code on back:** _____

Credit Card Number: _____ **Exp:** ___/____

Name As It Appears On The Card: _____

Cardholder Signature: _____

NOTE: Do NOT use this form if you are ordering replacements because your specimens were MISSING or ARRIVED damaged (broken, hemolyzed, etc.)

Contact MLE at 1-800-338-2746, ext. 4510 or mle@acponline.org