Free COVID Testing Program
Initial Information Form (IIF)

1. Company or Organization Name: ______________________________________
2. Address: ____
3. Contact Person's Name & Title: ________________________________
4. Contact Person's direct phone #: ________________________
5. Contact Person's email: __________________________
6. Organizations Physician's Name: _____________________________________
7. Physicians NPI Number: ________________________________
8. Company/Organization Website: _____________________
9. Proposed testing day(s) each week (circle all that apply): Mon Tues Weds Thurs Fri Sat Sun
10. Type of Test Kit Requested (circle one): Nasal (Anterior/Lower) or Saliva
11. Account Reps. Name: ___________________________

Please also complete the attached Location Information Form for each physical location at which we will be testing for your organization.

Location Information Form for ______________________________
Organization Name

Location Address:		
Contact Person:	Phone:	Email:
Number of People to Be Tested at Location:		

Location Address:		
Contact Person:	Phone:	Email:
Number of People to Be Tested at Location:		

Location Address:		
Contact Person:	Phone:	Email:
Number of People to Be Tested at Location:		

Location Address:		
Contact Person:	Phone:	Email:
Total Number of People to Be Tested at Location:		

Location Address:		
Contact Person:	Phone:	Email:
Total Number of People to Be Tested at Location:		

Please Print More Sheets for Additional Locations

5005 LBJ Freeway, Ste. 840, Dallas, TX 75244