express diagnostics international

I have read, understood and implemented the required actions.

DATE*: _____

AUTHROIZED SIGNATURE*: _____

PRINTED NAME*: _____

TITLE: _____ DEPT: _____

EMAIL*: _____

PHONE: _____ FAX: _____

PREFERRED RECEIPT OF RETURN LABELS: (Please Circle One) EMAIL FAX

*Required Information

To satisfy requirements for regulatory reporting, please complete and return this form, within 10 business days of receipt, to EDI at Fax Number 1-888-444-5754 or scan and e-mail to quality@drugcheck.com