Laboratory Information Systems Client Registration Form

Please complete this form electronically and return to: ClinicalLabOutreach@chop.edu. CHOP staff will then submit to LIS via ServiceNow Beaker request.

Submitting Department: _____
Name of Individual Submitting Form: _____
Date: _____
Institution Name (Client)*: _____
Report Address 1*: _____
Report Address 2: _____
City*: _____
State*: _____
Zip Code*: _____
Client Point of Contact Name*: _____
Client Point of Contact Email Address*: _____
Fax Number **or** email (to receive results)*: _____
Additional email(s) to receive results: _____

Billing Information

Please note: The billing contact name, phone number, and email address are mandatory fields (see the * below).
The billing address only needs to be supplied if the address is different from the report address above.

Billing Address 1: _____
Billing Address 2: _____
City: _____
State: _____
Zip Code: _____
Billing Point of Contact Name*: _____
Billing Point of Contact Phone Number*: _____
Billing Point of Contact Fax Number: _____
Billing Point of Contact Email Address*: _____

To Be Completed by LIS

Client Mnemonic: _____
Client Name: _____
Submitter Number: