

# CLINICAL DIAGNOSTIC SOLUTIONS QUALITY ASSURANCE PROGRAM (CQAP) U.S. ENROLLMENT FORM

Please fax completed form to  
954-791-7118

**LAB ID #** \_\_\_\_\_  
(Will be assigned by CDS)

**1.**

LABORATORY NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**2.**

CONTROL PRODUCT PART #: \_\_\_\_\_

INSTRUMENT: \_\_\_\_\_

INSTRUMENT ID#: \_\_\_\_\_  
(Serial number)

INSTRUMENT MODEL: \_\_\_\_\_

**3.**

QC CONTACT NAME: \_\_\_\_\_

TITLE OR POSITION \_\_\_\_\_

TELEPHONE: \_\_\_\_\_

EXTENSION: \_\_\_\_\_

FAX: \_\_\_\_\_

EMAIL: \_\_\_\_\_

**4.**

START MONTH: \_\_\_\_\_

**5.**

COMMENTS: \_\_\_\_\_  
\_\_\_\_\_