



NEW ACCOUNT FORM *(all fields must be completed)*

CAMP

Current Date: _____
 Submitting Representative _____

Camp NAME _____

Will A2Z be supplying swabber? Yes No Will QR codes need to be created for Camp Registration? Yes No

Number of Tests Needed for Camp				
Date Of Testing	Hours Of Testing	# of PCR	# of Antigen	# of Rapid PCR (Accula)

CAMP LOCATION & CONTACT INFORMATION

Address _____ Suite/Room/Floor _____
 City _____ State _____ Zip _____
 Main Phone _____ Cell Phone _____
 Camp Coordinator _____ Email _____

Patient Results

Will Camp Coordinator Receive all Patient Results? Yes No
 If YES enter Camp Coordinator EMAIL _____
 Would you like patients to receive results via Text or Email? Yes No

Payment

Insurance Yes No
 Client bill (Camp to be Billed & Pay for Testing for Uninsured/Foreign Individuals) Yes No
 Patient Pay (Uninsured/Foreign Individuals to Pay for Testing) * Yes No
 Camp to pay for A2Z swabber (\$) Yes No
**This option Requires A2Z approval*

Comments