NORTH CAROLINA STATE LABORATORY OF PUBLIC HEALTH
Attention: Customer Services
P.O. Box 28047, Raleigh, North Carolina 27611-8047
Telephone: 919-733-3937 Fax: 919-807-0730

Client Change of Information Form

Use this form to **change** your information when there has been a change of ownership, name, address, contact person, etc. Fill out entire form; see page 2 for instructions. **When completed, fax to 919-807-0730.** **Please print clearly**, so that the information will be entered correctly.

Please mark correct boxes: □ **Change of Ownership** □ **Other Changes**
What types of samples do you send? □ **Clinical** □ **Environmental** □ **Both Clinical & Environmental**

New or Current Name of Practice or Business:			Attention: (optional field)
Previous Name Of Business:			
New or Current Mailing address:		**Previous** Mailing address:	
City:	State:	City:	State:
County:	Zip:	County:	Zip:
Phone # with area code:			
Primary Fax # with area code:			
** **Current EIN/Tax ID #:**		** **Previous EIN/Tax ID #:**	
Shipping address: (if different from above)			
Shipping address (line 2):			
City:		State:	Zip:
Billing address for supplies: (if different from shipping address)			
Billing address (line 2):			
City:		State:	Zip:
Contact Person Name:			
Title:			
Phone # with area code:			
Email address:			
**Physicians Names & NPI #s			

***** Effective Date for Changes:*** ***Signature:***

Instructions for Change of Information Form

Fill in each section of requested information. It is important that this information be current and accurate. Please fill out the whole form, not just the updated information.

Change of Ownership: Mark this box if you have had a change in tax identification number (EIN).

What type of samples do you send: Clinical, Environmental, or both? Answering this question will help us in identifying what services you need.

Other Changes: Mark this box if you are already a client but need to change your address, phone number, EIN, or other information.

New Name of Practice or Business: Fill in the name used to identify the business, practice, or organization.

Attention (optional): Fill in the name or title of the person to whom reports should be directed. It will appear with the mailing address on the test result report.

Previous Name of Business: Fill in with the previous name if changed.

Mailing address: Fill in the location to which you want reports mailed. It may be either a street address or a P.O. Box address.

Phone # and Fax # with area code: Fill in the phone and fax numbers used to contact the area sending samples and receiving reports.

EIN/TaxID#: This is the federal tax identification number assigned to the organization or business. ***This is a required field***

Previous EIN/Tax ID#: If you are notifying us to change your EIN/Tax ID#, fill in the one previously associated with your organization or business. ***This is a required field***

Shipping Address: Fill in the location to which you want supplies shipped. It must be a street address. If it is the same as the mailing address, you can leave this space blank.

Billing Address for Supplies: Fill in the location where you want the invoice to go for supplies. If this is the same location as the shipping address, you can leave this space blank.

Contact person name, title, and email address: Fill in the identity of the primary contact person for this account along with phone number and email address. This is the person who will be contacted if there are questions about setting up the account or making changes to your account.

Physicians' Names and NPI #'s: This area is for all the Physicians to be listed for your facility along with their NPI numbers ***** THIS IS A REQUIRED FIELD*****

Effective Date for Changes: Fill in the date when the changes will be in effect.

*** If your practice needs access to our online test results, please contact us directly at 919-733-3937.***