



REQUEST FOR ELECTRONIC LABORATORY RESULTS REPORT

I. REQUESTOR

Last Name	First	Date	
Department Name		Fund #	DPA#
Telephone	Fax	Email	
<p>I understand that a fee of \$100/hr with a minimum of 2 hours will be charge for reports.</p> <p>Signature: _____</p>			

II. DATA REQUESTED (Please note that lab system stores data for 3 years. Data beyond 3 years can be requested from STOR.)

Summarize What Data Is Requested		
Brief Explain Why Report Is Needed		
Date Interval and Frequency Requested <input type="checkbox"/> One Time (specify date range) _____	<input type="checkbox"/> Timed Interval Start Date: _____ End Date: _____ <input type="checkbox"/> Daily <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Other	Delivery Mechanism <input type="checkbox"/> File On Disk <input type="checkbox"/> Email <input type="checkbox"/> FTP <input type="checkbox"/> Other

III. REQUEST REVIEW

SECTION MEDICAL DIRECTOR			
Name	Signature	Date	<input type="checkbox"/> Approve <input type="checkbox"/> Do Not Approve <input type="checkbox"/> Conditional Approval
Comments			
LIS MEDICAL DIRECTOR			
Name	Signature	Date	<input type="checkbox"/> Approve <input type="checkbox"/> Do Not Approve <input type="checkbox"/> Conditional Approval
Comments			
LABORATORY MEDICAL DIRECTOR			
Name	Signature	Date	<input type="checkbox"/> Approve <input type="checkbox"/> Do Not Approve <input type="checkbox"/> Conditional Approval
Comments			

PLEASE FAX REQUEST TO 415-353-1804, ATTENTION LARRY ROHE