



Facility Name: _____ Facility Number: _____

(Please check and provide the updated information only):

Change	Details
<input type="checkbox"/> Facility Name:	_____
<input type="checkbox"/> Testing/Procedures:	_____
<input type="checkbox"/> Medical Director:	_____
<input type="checkbox"/> Manager/Supervisor:	_____
<input type="checkbox"/> Address:	_____
<input type="checkbox"/> Phone Number:	_____
<input type="checkbox"/> Email:	_____
<input type="checkbox"/> Other (please specify):	_____

NOTES:

SIGNATURE

I have reviewed and confirm the above facility information is accurate.

Medical Director/Designate Name: _____
 Date: _____
 Signature: _____

Please submit completed form to the College:

Diagnostic Laboratory Accreditation Program
 College of Physicians & Surgeons of Alberta
 2700, 10020 – 100 Street NW
 Edmonton, Alberta T5J 0N3
diagnosticlaboratory@cpsa.ab.ca