LABORATORY TESTS PERFORMED
North Dakota Department of
Health Division of Health
Facilities
SFN 53285 (09-2002)

Facility/Laboratory Name				Date
Street Address/P.O. Box	City	State	Zip Code	Phone Number
Name of Person Completing Form				Title

*Please list the manufacturer's name and model of the instrument or manufacturer's name of the test kit used for patient testing. For example, do not list "hematology machine or strep kit." This will ensure that you will receive the correct certificate based on the tests performed in your laboratory. Please attach additional copies if more space is needed.

Name of Laboratory Test	*Name of Instrument or Kit	CPT Code	Specimen Type	Annual Test Volume

PLEASE RETURN COMPLETED FORM TO:

North Dakota Department of
Health Division of Health
Facilities
600 E Boulevard Ave., Dept. 301
Bismarck, ND 58505-0200