

# KENTUCKY CABINET FOR HEALTH AND FAMILY SERVICES

Division of Laboratory Services

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## Request for Examination

<b>Submitted By:</b>	<b>Agency:</b>
<b>Address:</b>	<b>Phone:</b>
<b>City:</b> <b>State:</b> <b>Zip:</b>	<b>Fax:</b>

### FOR STATE LAB USE ONLY

#### EXHIBITS:

<b>EOC NUMBER:</b>
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<b>LAB NUMBER:</b>
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State Lab Signatures:

<b>CT screening:</b>	<b>Date/Time:</b>
<b>BT testing:</b>	<b>Date/Time:</b>
<b>Specimen Storage:</b>	<b>Date/Time:</b>