AAFP PROFICIENCY TESTING

Reinstatement Proficiency Testing Results Form

AAFP ID#: _____ CLIA ID#: _____

COLA# (if applicable): _____

Practice Name: _____

Address: _____

City, State, ZIP: _____

Email Address: _____

Medical Director: _____

Testing Personnel: _____

Date of Testing: _____

EMAIL RESULTS TO pt@aafp.org

Note: Failure to provide complete information may delay the processing of your evaluation.

Analytes:_____ **Instrument/Method:** _____
(e.g., WBC, glucose, Strep Antigen)

Specimen ID	Your Result

AMERICAN ACADEMY OF FAMILY PHYSICIANS

11400 Tomahawk Creek Parkway
Leawood, KS 66211-2672
(800) 274-7911 | Fax: (913) 906-6079
aafp.org/pt

DPA18010046

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