Fairfax Cryobank

# Physician Account Set Up Form

www.fairfaxcryobank.com

Name: _____

Job title: _____

Clinic Email Address

**IMPORTANT!** Please print clearly

| | | |
|---|---|---|
| Physician Name(s) (list all physicians at clinic) – first name, last name | | |
| Medical License Number(s) | | |
| Clinic Name | | |
| Shipping Address(es) for delivery | | |
| City | State | Zip |
| Billing Contact Person | Lab Contact Person | |
| Phone Number | Fax Number | |
| Clinic Email Address | Website Address | |

**Physician's office provides:** ☐ Specimen washing ☐ Liquid Nitrogen Storage

Fairfax Cryobank requires that all clients are working with licensed physicians, and this form will be used to assist us in this verification process. By establishing an account, I understand and agree to the Terms of Use, if I purchase samples directly from Fairfax Cryobank,

**An information packet will be mailed to your office via Priority Mail, following this account setup.**