Laboratory Service Provider
Application Form

Name of Facility:

Name of Contact at Facility:

First: | Last:

Address:

Street Address/Location:

City: | Zone:

County: | Phone:

Email:

Is your facility registered with the Government of Liberia? If yes, what's the status of your Business Registration?

Status: ☐ Current ☐ Expired ☐ Renewal Process

Is your facility associated with the Liberia Medical & Dental Council or HFL? If yes, what's the status of your accreditation?

Status: ☐ Current ☐ Expired ☐ Renewal Process

Trans-LinX provides laboratory test courier services for healthcare facilities and their patients upon request.

I, the undersigned, do hereby certify that the information provided above is true and accurate. This information should only be utilized for the approval of my facility as a client of Trans-LinX delivery services.

Name:

First: | Last:

Signature: | Date:

Trans-LinX Use Only:

Client Number: | Date:

Approved by: | Date: