

KENTUCKY CABINET FOR HEALTH AND FAMILY SERVICES

Division of Laboratory Services

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Request for Examination

Submitted By:	Agency:
Address:	Phone:
City: State: Zip:	Fax:
Sample Screened for: Radiological () Chemical () Explosive () Biological ()	
Results: (attach a copy of results)	

FOR STATE LAB USE ONLY

EXHIBITS:

EOC NUMBER:

LAB NUMBER:

State Lab Signatures:

Specimen Preparation:	Date/Time:
Specimen Processing:	Date/Time:
Specimen Storage:	Date/Time: