

*Sprint Sports Rehabilitation, Inc.*  
*113 E. College Blvd.*  
*Roswell, NM 88201-5158*  
*(575) 622-6500 Phone*  
*(575) 622-9777 Fax*

**DATA INPUT SHEET**

(Please complete all information. If you are unsure about any item, please note it and we will contact you a.s.a.p. Until we receive this information, all services will be C.O.D.)

Date: \_\_\_\_\_

Company Name: \_\_\_\_\_

Contact 1: \_\_\_\_\_ Contact 2: \_\_\_\_\_

Physical Address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Office Phone: \_\_\_\_\_ Mobile: \_\_\_\_\_

MRO (Medical Review Officer) Name: \_\_\_\_\_

MRO Address: \_\_\_\_\_

MRO Phone: \_\_\_\_\_

Billing Company: \_\_\_\_\_

Billing Address: \_\_\_\_\_

Billing Contact Person: \_\_\_\_\_ Phone: \_\_\_\_\_

Billing Special Instructions or Other Information: \_\_\_\_\_  
\_\_\_\_\_

Circle Info Needed on Invoice for Person Tested:      Name    SSN    Specimen#    Reason for test

Circle:    DOT    NON DOT    Random Drawings    ECup

Courier: \_\_\_\_\_ Lab: \_\_\_\_\_

Additional Notes: \_\_\_\_\_  
\_\_\_\_\_