

ACCOUNT SETUP INFORMATION <i>Please print</i>		
Physician Name:		Title(s):
Facility Name:		
Mailing Address:		
City:		
State:	Zip (Postal) Code:	Country:
Email address:		
Phone:		Fax:
Contact Person:		Fed. Tax ID:
AUTOMATIC PAYMENT INFORMATION (optional)		
Cardholder Name:		
VISA/MasterCard:		
Exp. Date:	Security Code:	
Billing Address:		
Cardholder Signature:		
ATTESTATION		
I certify that I have read ISL's Payment Policy Information. I agree to comply with the terms and conditions contained therein. I attest that I am currently licensed , by the state in which I practice, to order the laboratory testing offered by Immunosciences Lab., Inc.		
Signature:		
Date:		
<input type="checkbox"/> Check this box, if you would like to be included on the ISL practitioner referral list.		