

## NSO COVID-19 SCREENING REQUEST FORM

Submission Date			
Name of National Sport Organization			
Name of Submitting Person			
		Email	
		Phone #	
Location of Testing (full address)			
Event Name			
Reasons for COVID-19 Screening			
Dates Required (inclusive of one-day return)			
Shipping Address (if different from Location of Testing)			
Name of Receiving Medical Practitioner			
Medical Practitioner bCUBE Training Status		Completed	Not Completed
Number of bCUBE test units required:			<small>NSOs are responsible for unused tests  If requested, please provide athlete list</small>
Number of Tests (24 per batch):			
Number of HP Athletes	NextGen		
	Senior National Team		
NSO has ensured available PPE for sample collection		Yes	No
<small>Briefly describe PPE and testing environment:</small>			
NSO HPD Name:  Signature:		NSO Medical Practitioner Name:  Signature:	