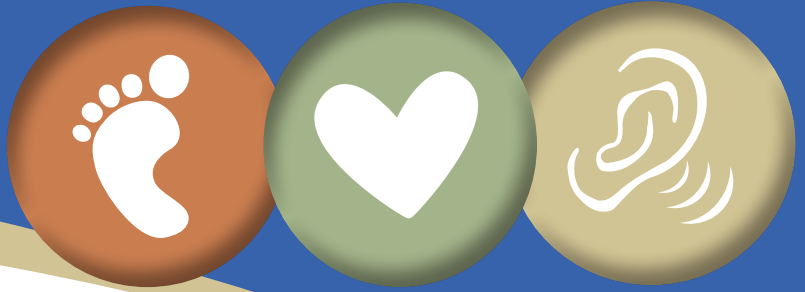


New Submitter Form

Minnesota Newborn Screening Program



Business Name (if applicable): _____

First Name: _____ Last Name: _____

Please provide the address where you would like all Newborn Screening correspondences to be mailed.

Mailing Address: _____

Phone: _____

Email Address: _____

Please return the portion above this line, and keep the bottom for reference.

You will be assigned a unique number which is called a *submitter number*. This number is important to include on the newborn screening card so we can identify who collected the blood and where the results need to be mailed. Once your information has been processed, we will contact you with your submitter number.

When completing newborn screening cards, please write your business name (if applicable) as the *submitter name*. Please use the *submitter number* we assign to you in the submitter number field on the screening card.

For detailed instructions on how to accurately fill out a newborn screening card, please refer to the screening card instructions on our website:

<http://www.health.state.mn.us/newbornscreening/providers/cardinstructions.html>



Newborn Screening Program
601 Robert St. N., St. Paul, MN 55155
Phone: (800) 664-7772* or (651) 201-5466*
Fax: (651) 215-6285 *translators available

