Bureau of Public Health Laboratories
Demographic Correction Request Form

Please fill in as much information as possible for each section. This information is crucial to performing the corrections.
Name and birth date must be provided, along with any proof of change. Form must be legible.
If DOH Employee, the completed form may be emailed to **DLBOLMIS@flhealth.gov**, otherwise, fax to (904) 791-1567.

IN REFERENCE TO REQUISITION NUMBER(S): _____

PATIENT INFORMATION

CORRECT:		**INCORRECT**:	
Last Name:		Last Name:	
First Name:		First Name:	
Birthdate:		Birthdate:	
SSN:		SSN:	
Address:		Address:	
Phone:		Phone:	
Gender:		Gender:	
Race:		Race:	
Ethnicity:		Ethnicity:	
Other (specify):		Other (specify):	

SPECIMEN INFORMATION

CORRECT:		**INCORRECT**:	
Collection Date:		Collection Date:	
Date Received:		Date Received:	
Specimen Source:		Specimen Source:	
Other (specify):		Other (specify):	

INFORMATION PROVIDED BY:

Source: _____

Provider's Name _____

Provider's Title: _____ Phone: _____

Provider's Signature: _____ Date: _____

For Internal Use Only:

Form Completed By: _____ Date: _____
Print Name

Signature: _____ Phone: _____

Revised: 10/12/2017 jgs