Form Approved
OMB Control No. 0920-0600
Exp. Date xx/xx/xxxx

Model Performance Evaluation Program for *M. tuberculosis*/Non-tuberculous Mycobacteria Drug Susceptibility Testing Program(MTB/NTM DST) Laboratory Information Change Form

Lab ID# Number:

Please indicate changes to be made to your current laboratory information:

1. Laboratory Name:

2a. Mailing Contact Person:

Name: _____

Title: _____

Telephone Number: _____ FAX Number: _____

E-Mail: _____

2b. Shipping Contact Person:

Name: _____

Title: _____

Telephone Number: _____ FAX Number: _____

E-Mail: _____

3a. Mailing Address of Laboratory (address which correspondence should be sent):

Street or PO Box: _____

_____

City: _____ State: _____

Country: _____ Zip/Postal Code: _____

3b. Shipping Address of Laboratory to which specimens should be mailed if different from above:
**Cultures can not be mailed to PO Boxes*

Street: _____

_____

City: _____ State: _____

4. Panels to be shipped to laboratory (check only one): ☐ *M. tuberculosis* **Only** ☐ NTM **Only**
☐ **Both** *M. tuberculosis* and NTM

5. Person Completing Form: _____

6. Today's Date: _____

Please email this form to aragin@cdc.gov or fax to 404 498-2372, Attention: MTB/NTM DST

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