

Use this form to report all non-elevated blood lead levels less than 3.5 µg/dL. Please print or type.
 Fax to (334) 206-3726 within 30 days of testing. Please call (334) 206-3883 if you have any questions. *Elevated blood lead levels greater than or equal to 3.5 µg/dL should be reported on the elevated blood lead reporting form within 5 days of testing.*

First Name		Last Name			
Date of Birth	Gender	Race(s)	Ethnicity	Medicaid #	
Street Address			City	State	Zip Code
Collection Date	Specimen: (Check one) ___ Venous ___ Capillary			Blood Lead Level _____ µg/dL	

First Name		Last Name			
Date of Birth	Gender	Race(s)	Ethnicity	Medicaid #	
Street Address			City	State	Zip Code
Collection Date	Specimen: (Check one) ___ Venous ___ Capillary			Blood Lead Level _____ µg/dL	

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Collection Date	Specimen: (Check one) ___ Venous ___ Capillary			Blood Lead Level _____ µg/dL	

Reporting Facility _____

Name of Sender _____ Phone _____