Partner Organization Form

Clinic/Agency/Organization Name: _____

Clinic/Agency Address: _____

City: _____ County: _____ Zip: _____

Main Contact: _____

Title: _____

Phone: _____ Fax: _____

Email: _____

Estimated number of FIT colorectal cancer stool testing kits to be provided over 12 month period: _____

Plan/Procedure to follow-up on positive or abnormal tests:

_____

_____

FIT Kit Program Acceptance of Terms:

I have read and understand the Wyoming FIT Kit Program Manual and agree to requirements outlined in the manual. I understand that test kits are purchased, provided and processed by the Wyoming Department of Health Cancer Program supported by the American Cancer Society. I agree to not receive reimbursement for any tests given to clients through the program that my clinic did not purchase. Test results and related protected health information will be kept confidential. I agree to share results from follow-up screenings with the program via phone, fax, or email. Statistics on the successes, challenges, barriers and best practices identified through this program may be published, including number of positive results identified and follow-up actions provided by the program.

Medical Director Signature: _____ Date: _____

Clinic/Agency Contact Signature: _____ Date: _____

If you have any questions please refer to the manual, call 307.777.8609 or email wdh.cancerservices@wyo.gov