

NIAGARA FALLS CITY SCHOOL DISTRICT

Patient/Employee Name \_\_\_\_\_ Building \_\_\_\_\_  
(Last name, First name, Middle Initial)

Street Address: \_\_\_\_\_ Zip Code \_\_\_\_\_

Residence County: \_\_\_\_\_ Phone Number with Area Code: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ (Male/Female)

Race/Ethnicity:  Asian  Black  Hispanic  Native American  White  Mixed Race/Ethnicities  Other

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**Health Care Professional to Complete all Sections that Apply:**

**Test Ordered:**

BinaxNOW™ COVID-19 Ag CARD SARS-CoV-2

Test Lot# and Expiration Date: \_\_\_\_\_/\_\_\_\_\_

Specimen ID/Source#:  Nasal swabs (445297001^Swab of internal nose^SCT)

Date of specimen collected: \_\_\_\_\_ Date of Test Result: \_\_\_\_\_

Test Result:  Negative (260385009^Negative^SCT)

Positive (10828004^Positive^SCT)

Invalid (455371000124106^Invalid result^SCT or 125154007^Specimen unsatisfactory for evaluation^SCT)

Physician Name Jo A. Silvaroli DNP, FNP / Address 630-66 th Street NF NY 14304 / Phone#: 716-286-0787

Physician NPI (as applicable): \_\_\_\_\_

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**Reference:** [www.hhs.gov](http://www.hhs.gov). Public Law 116-136, § 18115(a), the Coronavirus Aid, Relief, and Economic Security (CARES) Act, requires “every laboratory that performs or analyzes a test that is intended to detect SARS-CoV-2 or to diagnose a possible case of COVID-19” to report the results from each such test to the Secretary of the Department of Health and Human Services (HHS).

**I certify that the information submitted in this “Attestation” is true and correct to the best of my knowledge.**

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Date: \_\_\_\_\_