

AGT INTERNATIONAL DIRECTORY
INFORMATION FORM

This form is to be completed by the Laboratory Director or Supervisor and returned to: AGT Executive Office, P.O. Box 15945-288, Lenexa, KS 66285-5945 USA. Please use this form only if your lab does not appear in the current Directory.

Institution Name _____

Department/Division _____

Laboratory Name _____

Building/Room Number (if applicable) _____

Street Address _____

City, State, Zip Code _____

Country (if not USA) _____

Telephone Number _____ FAX _____

E-mail _____

Director's Name _____

Supervisor's Name _____

Disorder Type (Circle Letter)	Method** (letter(s))	Disorder Type (Circle Letter)	Method** (letter(s))
A Cystic fibrosis	_____	Q Sickle Cell	_____
B Duchenne muscular dystrophy	_____	R Spinal muscular atrophy	_____
D Factor V Leiden	_____	S Thalassemia (alpha & beta)	_____
E Fetal Sex	_____	T Other	_____
F Forensic/Paternity	_____		
G Fragile X	_____	Cancer	
H Gaucher disease	_____	U APC (colon cancer)	_____
I Hemochromatosis	_____	W BCR for Philadelphia chromosome	_____
J Hemophilia A	_____	X Ig rearrangement	_____
K Huntington disease	_____	Y BCL (all types)	_____
L Spinocerebellar Ataxias (all types)	_____	Z n-MYC amplification	_____
M Myotonic dystrophy	_____	AA TCR rearrangement	_____
N Neurofibromatosis (NF-1)	_____	BB MLL	_____
O Prader Willi/Angelman	_____	CC Other	_____
P Multiple Endocrine Neoplasia (all types)	_____		

****Method** (place appropriate letter in column above)

- a PCR
- b Southern blot
- c PCR and Southern blot
- d Other

The following questions are for demographic purposes only and will not be printed in the directory:

How many technologists are employed in your lab? _____

How many of those technologists are AGT members? _____

How many of these technologists are certified by NCA? _____