Request Form for Telehealth Administration

Stoelting proprietary products only

Requester and Contact Information	
Current date:	
Clinician name:	
Clinician email:	
Credentials of clinician conducting telehealth administration:	
Institution/Business name:	
Are you the primary contact?	☐ Yes ☐ No
If not, who is the primary contact?	
Primary contact email:	
Primary contact phone:	
Are you a student and/or working under supervision?	☐ Yes ☐ No
Supervisor's name and credentials:	

Stoelting Assessment Information	
Stoelting assessment requested for telehealth administration:	
Describe remote administration: (e.g., document reader, EMR)	
List any modifications to standardized administration:	
Number of sites where telehealth administration will occur:	

After completing this form, please email it to psychtests@stoeltingco.com to submit your request.