Maine Center for Disease Control and Prevention
An Office of the Department of Health and Human Services

Department of Health and Human Services
Health and Environmental Testing Laboratory
221 State Street
12 State House Station
Augusta, Maine 04333-0012
Tel: (207) 287-2727; Fax: (207) 287-6832
TTY: 1-800-606-0215

FLUORIDE TEST KIT REQUEST

Name:_____Telephone #_____

Address: _____

Town, State, Zip Code: _____

The cost of the fluoride test is $20.00. Please enclose a check or money order made out to "Treasurer, State of Maine". Do **not** send cash. For your convenience, payment may be made by Visa or MasterCard.

Visa ☐ MC ☐ Card Number ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ Expiration Date ☐☐/☐☐

_____ $ _____

Signature of Card Holder Amount

If you have a problem paying for this test, the cost **may** be waived.
However, you must meet **ALL** of the following conditions.

☐ The water you drink comes from a private well, and not from a public water system.

☐ There is an existing health condition or a professional reason to get this test result. Examples include:
- ☐ a medical or dental health provider's advice that your water be tested because of an existing illness or health-related need, such as existing dental disease (tooth decay), a high risk for dental disease, and/or the need to determine the correct level of fluoride supplements **OR**
- ☐ unnatural contamination, such as suspected waste or spills that contaminate nearby groundwater.

☐ You provide proof that you participate in any of these programs: Food Stamps, TANF, WIC, or MaineCare.
Write the program name and your ID number in the spaces at the bottom of this form.

☐ **You must provide the information listed here at the same time as this test request**.
Please write the name of the program and your ID number in the spaces below, and enclose a copy of the medical or professional justification with this form, **or,** use the list as a checklist and have the health provider sign it. **Please note: If all of the requested information is not submitted together with this request, your request for a fee waiver will be denied.**

Program Name: _____ ID Number: _____

Health Provider signature: _____

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