ethide laboratories

TEST REQUEST FORM

SEND TO:
1300 Main Street,
West Warwick, RI 02893

For Lab Use Only
Customer Requirements PO_____ TRF_____ Other_____
Test(s) Code(s)_____/_____
Procedures_____
Capabilities_____Resources_____
Amendments (not required)_____ See Attached_____
Accepted_____ By_____

Date Received_____By_____

Traceable Reference #: _____

Send Report To:

Invoice To: (if different) **P.O:**_____

_____ _____
_____ _____
_____ _____
_____ _____

Phone #:_____ Fax #:_____

Sample Description: (Use exact wording desired on final report)

_____
_____
_____
_____

Lot No.(s): _____

Perform the following test:

# of Test(s)	Test Type/Description	Test Code #
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Samples are: ☐ Sterile ☐ Non-Sterile **Sterilized By:** ☐ EO ☐ Radiation

Comments: (Not typed on final report)

_____
_____
_____

_____ _____
Signature Date