



ETHIDE
LABORATORIES

For Lab Use Only

Customer Reqmts.

PO ☐

TRF ☐

Other ☐

TEST REQUEST FORM

Test(s)

Code(s)

Procedures

Capabilities

Resources

SEND FORM TO:

1300 Main Street
West Warwick, RI
02893

Amendments (not Required) ☐

See Attached ☐

Accepted Date

By

Date Received

By

Traceable Ref #:

P.O. #

Send Report to: (Company name, address, attention)

Invoice To: (if different)

Phone #:

Fax #:

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

Lot Numbers:

Perform the following tests:

Normal TAT ☐

RUSH ☐ (must be previously agreed upon, RUSH charges apply)

Number of Tests

Test Type / Description

Test Code #

Samples are:

☐ Sterile

☐ Non-Sterile

Sterilized By:

☐ EO

☐ Radiation

Comments: (Not typed on final report)

Signature

Date