

F-0164-03

**BIO-CONCEPT LABORATORIES, INC.
LABORATORY TEST REQUEST FORM**

Photocopy this form and provide legible information as required. Submit one completed form with each sample to be tested. **A signed test request form is required for tests to be scheduled.**

Date Shipped: _____ PO Number: _____

Send with sample to:
Bio-Concept Laboratories, Inc.
Attn: Laboratory Testing
13 Industrial Way
Salem, NH 03079
Phone: (603) 437-4990
Fax: (603) 893-7240
Email: tests@bioconcept.com

Please choose one of the following:
1 Business Day 3 Business Days
7 Business Days 15 Business Days

Samples received after 10:30 am EST will be checked in on the next business day.

Send results to:

Send invoice to (if other than report address):

ATTN: _____
Phone: () _____
e-mail address: _____

ATTN: _____
Phone: () _____
e-mail address: _____

SAMPLE NAME	LOT NUMBER	AMOUNT SUBMITTED	RETURN*	DISPOSE*

* Specify either sample return (\$100/sample S&H) or disposal (\$15/sample).

TESTS REQUIRED	SPECIFICATIONS**	METHOD
1.		
2.		
3.		
4.		
5.		
6.		
7.		

** If based on label claim, provide claimed amount.

Special Instructions: _____

Client Test Authorization Signature: _____ Date: _____

For Bio-Concept Laboratories, Inc. Use Only:

Date Received: _____ Received By: _____ TA #: _____
If received after 10:30AM EST samples should be logged in as received the following business day.