

CONTRACT TEST SERVICE

Sample Submission Form



COMPANY NAME: _____
 CONTACT NAME: _____
 NUMBER OF SAMPLES IN SHIPMENT: _____

Laboratory Use Only

Internal Control Number: _____ - _____
 Customer ID Number: _____

Sample Identification*	Lot Number	Concentration or Maximum Dose	Endotoxin Limit	Dose	pH	Storage Temp.**

*If additional space is required, use multiple forms.

** If no storage temperature is indicated, the samples will be stored refrigerated.

TYPE OF SAMPLE

- Biological
- Biotech
- Chemical
- Intrathecal
- Medical Device
- Parenteral
- Pharmaceutical
- Polymer
- Water
- Tissue
- Other: _____
- Serum: _____
- Controlled Substance** Yes No

TEST TYPE

- Product Characterization
- Method Development
- Validation (Inhibition/Enhancement)
- Release (Limits) - Finished Product
- Release (Limits) - Components/ Raw Materials

TEST ASSAY - SELECT ASSAY TYPE

Gel-clot

- Gel-clot Assay
- Endotoxin Specific

Turbidimetric

- Kinetic Assay
- Endotoxin Specific

Chromogenic

- Pyrochrome®
- Kinetic Assay
- Endotoxin Specific

Chromogenic

- Chromo-LAL Kinetic Assay
- GlucateLL® Kinetic Assay
(Glucan Specific, Research Use Only)

INSTRUCTIONS

- ⇒ When sending multiple samples from one lot, indicated the following: _____ Test Samples Individual _____ Test Samples Pooled
- ⇒ For product release, list IC numbers of validations (if known): _____
- ⇒ Recommended method for reconstitution or extraction: _____
- ⇒ Handling precautions: _____
- ⇒ Recommended method of sample disposal: _____
- ⇒ Special Instructions: _____
- ⇒ Send MSDS for sample (or letter stating handling precautions). **If not included, no testing will be performed until received.**
- ⇒ Expedited Services:
 - Rush test service - 48 hour study initiation (charges are double) Yes No
 - STAT test service - 24 hour study initiation (charges are quadruple) Yes No

Comments

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Internal Control Number: _____ - _____

BILLING INFORMATION

Company Name: _____
Attention: _____
Address: _____

Phone: _____
Fax: _____

Please check method of payment:

Purchase order number: _____
Credit card: Visa Mastercard American Express
Number: _____
Security Code: _____
Expiration Date: _____
Name on Card: _____
Signature: _____

REPORTING INFORMATION

Company Name: _____
Attention: _____
Address: _____

Phone: _____
Fax: _____
E-mail: _____

Reports:

An original report will be sent by mail to the above address. A PDF copy will be emailed upon request.

E-mail (PDF - non encrypted)

Report Only
 Report and Raw Data

SHIPPING INFORMATION

*Samples should be sent to the following address:

**Contract Test Service
Associates of Cape Cod, Inc
124 Bernard E. St. Jean Drive
East Falmouth, MA 02536**

*Details for shipping samples can be found in the CTS Pricelist.

CONTACT INFORMATION

Phone: 508-540-3444 or 888-232-5889
Fax: 508-540-2019

Website: www.acciusa.com/cts

Email: testservice@acciusa.com

INTERNAL USE ONLY

Sample/package condition upon receipt:

Physical condition: _____ Technician Initials: _____ Date: _____

Arrival/Storage Temperature: _____

Number of Samples Received: _____ Agreement with number shipped: Yes No

Sample Status: Acceptable; no action required. Requires Customer Notification

Reason for Notification: Sample Damaged Sample lost/missing Inappropriate storage temperature Other*

*Explanation: _____

Customer Contact: _____ Date: _____ Contacted by: _____

Comments/Resolution: _____

Action Required: _____

If additional space is required, attach a separate sheet.

Verified by: _____

Initial/Date