

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

- Chemical
- Medical Device
- Pharmaceutical
- Parenteral
- Biological
- Intrathecal
- Tissue
- Adult
- Child
- Controlled Substance Yes No
- Other: _____

TEST TYPE

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

TEST ASSAY - SELECT ASSAY TYPE

Gel-clot

- Gel-clot Assay
- Endotoxin Specific Gel-clot Assay

Turbidimetric

- Kinetic Assay
- Endotoxin Specific - Turbidimetric Assay

Chromogenic

- Kinetic Assay
- Endpoint
- Endotoxin Specific - Chromogenic Assay
- Chromo-LAL Kinetic Assay
- Endospey® (Research Use Only)
- GlucateLL® Kinetic Assay (Glucan Specific, Research Use Only)

INSTRUCTIONS

- ⇒ When sending multiple samples from one lot, indicate 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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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) Fax

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/contract
Email: testservice@acciusa.com

INTERNAL USE ONLY

Sample/package condition upon receipt:

Physical condition: _____ Initials: _____ Date: _____

Arrival/Storage Temperature: _____

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

Sample Status Acceptable Requires Customer Notification

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

Customer Contact: _____ Date: _____ Analyst: _____

Comments/Resolution: _____

Action Required: _____

If additional space is required, attach a separate sheet.