



# TESTING LAB REQUEST FOR SAMPLES FORM

Please Print

Send copy to BBPSP Attn: T.Soll Fax:780-401-3067

Keep original on file in Lab.

<b>General Information</b>	Date: _____
Name of Investigator: _____	
Clinic/Lab Name: _____	
Address: _____	
City: _____ Province/State: _____	
Postal/Zip Code: _____ Country: _____	
Association: _____	

## Requested Samples

Type	Quantity	Subtotal
<input type="checkbox"/> DNA		
<input type="checkbox"/> RNA		
<input type="checkbox"/> Serum		
<input type="checkbox"/> Cells		
	<b>TOTAL</b>	

## Statement of Testing

Type:  Virus  Mutation

Description: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## Waiver

The genetic material and serum samples will not, in any way, be sold or used for any commercial purpose. No other work, other than what is outlined in this protocol can be done with the samples. Any additional research, not covered by this consent, must have a new informed consent and protocol.

Date: \_\_\_\_\_ Investigator Signature: \_\_\_\_\_

**BBPSP** (do not write in this area)  
 Request Granted  Request Denied

Dr. Bruce Ritchie: \_\_\_\_\_

Notes: \_\_\_\_\_  
 \_\_\_\_\_