DESTRUCTION OF SAMPLES

Please Print

**** Send corresponding clinic a copy of this form and instruct them to keep it in their clinic file**

CHR # _____ **Date**_____

Clinic Name:

This patient wishes to have their samples destroyed.

☐ Withdrawal Form received

☐ Samples pulled from Freezers & storage areas

Storage Item Identifier	Date Destroyed	Destroyed By	Date Samples used

Form completed by: _____ _____ _____

Printed Name Date Signature

Notes:

_____

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