

**SAMPLE SUBMISSION FORM**

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| **CLIENT INFORMATION:**  |
| Company: |  | 2660 Schuyler Ave, Suite A. Lafayette, IN 47905-3964 PH: 765.588.6200 samplesubmission@tricliniclabs.comDEA: RT0386335 |
| Contact Name: |  |
| Mailing Address: |  |
| City, State, Zip: |  |
| Phone: |  |
| Email: |  |
| DEA # (if applicable) |  |
| Proposal or Quote #: | (REQUIRED) |
| SIGNATURE: |  |
| **BILLING INFO:** |
| Contact Name: |  |
| Billing Address: |  Same as above |
| City, State, Zip: |  |
| Phone: |  |
| Email: |  |
| Method of Payment: | PO CREDIT CARD (processing fee may be applicable) |
| PO# or Credit Card #: |  |
| Name on Credit Card: |  |
| Exp. Date: |  |
| Security Code: |  |
| Billing Zip Code: |  |
| **Material Name (SDS Required)** | **BATCH or LOT #** | **Analysis (es) Requested** | **Return Sample?\*** | **Classification** | **Storage** |
|  |  |  | Yes No | NormalCONTROLLED Subst.Potent | AmbientRefrigeratorFreezerLight Sensitive |
|  |  |  | Yes No | NormalCONTROLLED Subst.Potent | AmbientRefrigeratorFreezerLight Sensitive |
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| Additional Information (i.e., special sample handling/preparation instructions, specific data acquisition parameters, reporting requirements, etc.)Please provide a UPS/FedEx account number or a shipping label if sample return is requested |  |

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