Sterility Test Request Form

STERIS

Customer Information		
	Company	**Customer Code**
	Street Address	**City, State ZIP**
	Bill To Company	**PO # or Credit Card #**
	Contact Person	**Phone #**
	Email report to	**Quote #**

Sample Handling Information

Testing Priority
- ☐ STAT (MS/02 fee)
- ☐ Standard

Sample Storage Conditions
- ☐ Room temperature
- ☐ Refrigerate
- ☐ Freeze

Non-Destructive Testing
- ☐ Yes
- ☐ No

Post-Test Sample Handling
- ☐ Return (MS/01a fee)
- ☐ Discard

Hazardous Material
☐ No ☐ Yes (SDS/MSDS required for hazardous or chemical product)

Shipping info for Return Product

Ship Method	☐ UPS ☐ FedEx ☐ Pick up ☐ Courier
Courier Company	
Account #	
Method Priority	
Ship To Company	
Attention To	
Street Address	
City, State ZIP	

Product Information

Please use exact wording you want to appear on final report

Sample Name / Description

Unique Identification (Lot #, PN, Batch #, etc.)

Product Registration
- ☐ Allograft Tissue
- ☐ Medical Device
- ☐ Other Specify:

Cycle Type
- ☐ Sublethal ☐ Routine
- ☐ Half ☐ Gamma Dose
- ☐ Full ☐ NA

Test Information

- ☐ ST/01: Spore Strips / PCD
- ☐ ST/02: Inoculated Threads
- ☐ ST/03: Self-Contained / PCD
- ☐ ST/05: Inoculated Product – Direct Transfer
- ☐ ST/06: Inoculated Product - Filtration
- ☐ ST/07: Native Product – Direct Transfer
- ☐ ST/08: Native Product – Filtration
- ☐ ST/09: Gamma Dose

Method Validation

☐ BF/01: Method Validation Qty*: *3 per media type

Sample Quantity:

PC (+) Quantity:

BI Lot:

BI Expiration:

PCD Type:

PCD Lot:

Method Validation or PD #:

Alternate Incubation Requirements: ☐ No ☐ Yes, specify below

Special Instructions	

Signature		**Date**	

Lab Use Only	**Date Received**	**TRF #**	**Sample #(s)**
	Received By		