



Mailing Address:
 4444 Southwest 71st Avenue
 #112
 Miami, Florida 33155, USA

Contact Information:
Sales@ParticleShape.com
www.ParticleShape.com
 Phone: USA+ 305-801-7140
 Fax: USA+ 305-574-7800

SERVICE REQUEST FORM

COMPANY NAME: _____ **REQUEST DATE:** _____
ADDRESS: _____
CONTACT NAME: _____
(sample inquiries and reporting) **TITLE:** _____
EMAIL ADDRESS: _____ **PHONE NO.:** _____

NOTE: Completed Service Request Form, SDS (or equiv.), and Purchase Order are required before sample(s) can be processed.

INSTRUMENT AND SYSTEM FLUID INFORMATION

- Particle Insight Sentinel Pro *Analysis Type:* Size & Shape distribution
Suspension fluid (if known): _____
- Multisizer 4 Coulter Counter *Analysis Type:* Size distribution Surface Area Concentration (particles per mL)
Electrolyte (if known): _____
- LS 13 320 Laser Diffraction *Analysis Type:* Size distribution Surface Area
Module (if known): Universal Liquid (0.04-2000 µm) Aqueous Liquid (0.04-2000 µm)
 Micro Liquid (0.4-2000 µm) Dry Powder System (0.4-2000 µm)
Suspension fluid (if known): _____

SAMPLE DETAILS Affix additional sheet(s), if necessary.

Vision LAB ONLY	ITEM NO.	UNIQUE IDENTIFIER (i.e. lot no. batch no.)	DESCRIPTION	ESTIMATED SIZE RANGE (if known)
S-VA	1			
S-VA	2			
S-VA	3			
S-VA	4			
S-VA	5			

STORAGE CONDITIONS -80°C -20°C 4-8°C RT Other (specify): _____

PREPARATION INSTRUCTIONS As per Vision Analytical's determination As per previous analysis (*indicate S-IST no.* _____)

Diluent (*specify*) _____ Sonication (*indicate intensity & time*)

Dispersant (*specify*) _____ Vortexing (*indicate intensity & time*)

Comments:



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SUPPLEMENTAL REFERENCE DOCUMENTATION Include part number and version/revision date. Attach document(s) to this form.

Specification: _____
 SDS: _____

SERVICE TURNAROUND TIME (in business days)

For ALL new customers: Standard with R&D (5-7)
 For recurring customers: Standard (3-5) Express (2)* Expedited (1)*
 * Pre-approval required. Vision Analytical may limit the quantities eligible.

SAMPLE RETURN: Return sample(s) after analysis completion: No Yes (If yes, please provide shipping information below):

Carrier: UPS FedEx Other (specify) _____
 Carrier Account No.: _____

PAYMENT INFORMATION: *Payment Terms: NET 30 DAYS. Note that new customers or current customers with delinquent payment history may be requested to prepay before services are rendered.*

Quotation No.: _____ Purchase Order No.: _____

Billing Contact, if different from above (name, email address, phone number): _____

By signing below, I have agreed to the cost and payment terms, and I authorize Vision Analytical to perform the service described above.

PRINTED NAME & SIGNATURE

TITLE

APPROVAL DATE