

Food Test Request Form

Note: Fields marked with an asterisk(*) are mandatory.

Section 1: Collected at

Establishment*	Phone Number*	
Address	Email	
City	State	Zip

Section 2: Billing (skip if same as Section 1)

Establishment*	Phone Number*	
Address	Email	
City	State	Zip

Section 3: Sample Information

Collected by*	Collected Date/Time*	Date Shipped:
Carcass ID	Age	Source Info
Other ID#	Lot Size	Lot Held? <input type="checkbox"/>
		Program* <input type="checkbox"/> MPI <input type="checkbox"/> CIS <input type="checkbox"/> Industry

Section 3: Tests Requested* (Record number of specimens in greyed area and check test boxes)

Ground Beef <input type="checkbox"/> Beef Trim <input type="checkbox"/> Raw Components <input type="checkbox"/> Kidney <input type="checkbox"/> Carcass Sponge <input type="checkbox"/> <input type="checkbox"/> Salmonella <input type="checkbox"/> Residue <input type="checkbox"/> Generic E. coli <input type="checkbox"/> STEC (E. coli O157 / Big 6)	RTE Meat <input type="checkbox"/> Environmental <input type="checkbox"/> Food Contact Sponge <input type="checkbox"/> <input type="checkbox"/> Salmonella <input type="checkbox"/> Listeria spp. <input type="checkbox"/> Listeria monocytogenes <input type="checkbox"/> Listeria monocytogenes	Check if samples to be composited <input type="checkbox"/>
Other _____ Other _____		

Section 4: Record Sample IDs

Sample Number	ID
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	

Section 5: Sign chain of custody

Submitter Signature*	Date/Time
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LAB USE ONLY	Sample temp at receipt: °C	
	Receiving Signature	Date/Time
	Releasing Signature	Date/Time
	Receiving Signature	Date/Time
	Releasing Signature	Date/Time
	Receiving Signature	Date/Time