UC San Diego
SCHOOL OF MEDICINE

GLYCOANALYTICS CORE
REQUEST FOR ANALYTICAL SERVICES

ALL FIELDS REQUIRED UNLESS OTHERWISE INDICATED. COMPLETED FORM MUST BE SUBMITTED WITH YOUR SAMPLES.

ANAYLSIS REQUESTED BY _____ **DATE** _____

NAME _____

EMAIL _____

PHONE (___) ___-____ x_____

ADDRESS _____

_____

_____

INSTITUTION NAME _____

TYPE ☐ Academic ☐ Nonprofit ☐ For-Profit

PRINCIPAL INVESTIGATOR _____

BILLING CONTACT

NAME _____ PHONE (___) ___-____ x____

EMAIL _____

Payment Method (please check one)

- ☐ Service Agreement _____
- ☐ Purchase Order # _____
- ☐ Check (payable to UC Regents, remit to: UC San Diego GlycoAnalytics, 9500 Gilman Dr. #0687, La Jolla, CA 92093-0687)
- ☐ Wire Transfer
- ☐ University of California Recharge _____

UC San Diego Customers

Project # _____ Funding Source # _____

Task # _____

QTY	CATALOG #	DESCRIPTION/SAMPLE NAME	UNIT PRICE	TOTAL PRICE
			TOTAL	

As the PI of this project, I verify that all regulatory compliance issues surrounding biosafety and/or the procurement of animal or human samples have been completed and approved according to all applicable University, State, and Federal requirements.

Principal Investigator signature _____

COMMENTS OR SPECIAL INSTRUCTIONS: _____

_____

Please acknowledge UC San Diego GlycoAnalytics if data generated by the GlycoAnalytics is used in publications.

GlycoAnalytics Use ONLY. Please do not write below this line.

Date Received _____ Results Sent _____ Date Billed _____

Requisition # _____ Work Completed by _____