Libertyville – General
Test Request Form

Ship samples and completed form to: STERIS • 1880 Industrial Drive Libertyville, IL 60048 • (847) 367-5110

Customer Information

Company:
Street Address: **Bill to Company:**
City, State ZIP: **PO / Last 4 Credit Card #:**
Contact Person: **Quotation # (if known):**
Phone/Email Report to:

Product Information

Sample Description /
Part #:
Unique Identifier
(Lot, Run #, etc.):
Product Registration
(Medical Device, Tissue, Cosmetic, etc.):
Samples contain hazardous material. To prevent testing delays, please attach SDS to this request. ☐ Yes ☐ No

Testing Information

☐ **Irradiation Required** – select modality and dose range
☐Ebeam ☐Gamma ☐X-ray : kGy to kGy

☐ **Method Suitability (B&F)** **Qty to test:**
☐ Method Validation (1 media), 3 samples
☐ Method Validation (2 media), 6 samples

☐ **Recovery Efficiency (RE)** **Qty to test:**
☐ Method Validation-Inoculated (Preferred)
☐ Method Validation-Exhaustive (Native)

☐ **Sterility** **Qty to test:**
Method Reference (if known):

☐ **Bioburden**- select recovery type(s) **Qty to test:**
☐ Aerobe ☐ Fungi ☐ Anaerobe ☐ Sporeformer
Alert Limit: ☐ Gram Stain **Qty:**
Action Limit:
Method reference (if known): ☐ Microbial ID **Qty:**

☐ **Endotoxin** **Qty:**
☐ Kinetic Chromogenic ☐ Kinetic Turbidimetric
Method reference (if known):
Endotoxin only: indicate if product is
☐Intraocular ☐Cardiovascular/Lymphatic
☐Intrathecal ☐Other:

Additional samples may be requested in order to determine preliminary processing information

Special Instructions

Check all that apply. Provide details in "Notes" below. ***(Additional charges may apply)***
☐ STAT processing requested
☐ Refrigerate samples prior to testing
☐ Freeze samples prior to testing
☐ Pooled results **For sample return please complete below**
☐ Samples contain human allograft tissue **Ship to:**
☐ Do not cut or destroy samples during testing **Carrier:**
☐ Return test samples (provide shipping information to the right) **Account #:**
☐ Return extra samples (provide shipping information to the right) **Priority:**

Notes

Approval

By signing and dating below, I acknowledge I have read, understand and accept STERIS Terms and Conditions

_____ _____
Signature (testing cannot proceed without signature and date) ***Date***

STERIS ONLY

Date Received: TRFID#:
Received By:

All microbial identification will be sourced to STERIS AST Laboratory Brooklyn Park, or other ISO 17025 accredited laboratory; however, Customer may request microbial identification samples to be sent to an alternative external laboratory service provider. Please indicate alternative site for external laboratory testing in the Notes above.