



ANALYTICAL SERVICES

5965 Harrison Drive, Suite 8

Las Vegas, NV 89120

(702)367-1187 FAX (702)367-3031

SPORE TEST CHAIN OF CUSTODY FORM

COMPANY NAME: LAB INVOICE/SAMPLE NO:

CONTACT NAME:

COMPANY ADDRESS:

STREET

CITY

STATE

ZIP CODE

CONTACT PHONE:

CONTACT CELL:

ORIGINAL: MAILING ADDRESS :

CIRCLE: PICKUP or MAIL STREET CITY STATE ZIP CODE

EMAIL OR FAX COPY (1): ATTENTION:

EMAIL OR FAX COPY (2): ATTENTION:

WOULD YOU LIKE A COPY SENT TO SPECIAL PROGRAMS/SOUTHERN NEVADA HEALTH DISTRICT? YES OR NO

SAMPLING INFORMATION

Sterilizer Tested: Model:

Make:

Serial No:

Sterilizer Run Date: Run Time:

Minutes Sterilized:

Sterilizer Type: [] Autoclave (steam) [] Dry Heat [] Other

Spore Strip Lot#: Expiration Date:

Sampled By*: PRINT NAME SIGNATURE

* SAMPLER ATTESTATION: I understand that tampering or intentionally mislabeling the sample location, date, and time of collection may be considered fraud and subject to the provision of NAC445A

RELINQUISHED BY: PRINT NAME SIGNATURE COMPANY DATE

RECEIVED BY: PRINT NAME SIGNATURE COMPANY DATE

RELINQUISHED BY: PRINT NAME SIGNATURE COMPANY DATE

RECEIVED BY: PRINT NAME SIGNATURE COMPANY DATE

Report Due Date:

Additional Notes or Comments: ANALYTICAL SERVICES