

**METAL LPT KIT ORDER FORM**

**FAX: 303.270.2175**

**EMAIL: ClinRefLabs@njhealth.org**

**CLIENT INFORMATION**

Account Name: \_\_\_\_\_ Account Number: \_\_\_\_\_

Contact Name: \_\_\_\_\_

Contact Phone: \_\_\_\_\_ Contact Fax: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**KIT REQUEST**

Date Needed By: \_\_\_\_\_

Quantity of Kits (\$12.00 per Kit. **Minimum Purchase of 5 Kits**) : \_\_\_\_\_

Quantity of Kits (\$20.00 per Kit. **<5 Kits**) : \_\_\_\_\_

*\*An additional shipping charge of \$75 will be added to overnight or expedited shipments.*

Kits and tubes can also be purchased directly from [www.fishersci.com](http://www.fishersci.com) Catalog No. 22-130-027

**PAYMENT**

- Bill facility       Check payment enclosed with sample
- Credit Card: (circle one) Visa   MC Discover American Express  
Name on credit card: \_\_\_\_\_ CVV # (Security code) \_\_\_\_\_  
Credit Card #: \_\_\_\_\_ Expiration: \_\_\_\_\_  
Billing Address: \_\_\_\_\_

**COMMENTS**

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\_\_\_\_\_

**PLEASE ALLOW TWO WEEKS FOR DELIVERY**