ARTHROPOD/INSECT TEST REQUEST FORM

SUBMITTED BY: _______________________________ DATE COLLECTED: __/__/__

PERSON BITTEN: _______________________________ AGE: __________

ADDRESS: ____________________________________________

CITY, STATE, ZIP CODE: _________________________________

CONTACT PHONE #: ___________________________ FAX #: ______________________

GEOGRAPHICAL LOCATION WHERE TICK WAS ACQUIRED (AREA, COUNTY, STATE, ETC.)

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SEND REPORT TO (FULL ADDRESS): BILL TO (NAME OF ORGANIZATION):

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Payment Received By: __________________________Date: ______________________

CASH _____________ CHECK # __________________