



ARTHROPOD/INSECT TEST REQUEST FORM

Submitted by: _____ Date Collected: ___/___/_____

Person Bitten:			
Address:			
City, State:		Zip Code:	

Geographical Location Where Tick Was Acquired (Area, County, State, Etc.)

Result:

Billing information (Inhouse only)

Send Report to (Full Address)	Bill to (Name of Organization)
As above <input type="checkbox"/>	

For Lab staff use only:

Payment Received By		Date:	
Cash <input type="checkbox"/>	Check#	Credit Card <input type="checkbox"/>	Debit Card <input type="checkbox"/>