



ARTHROPOD/INSECT TEST REQUEST FORM

Submitted by: _____ **Date Collected:** ____ / ____ / ____

Person Bitten:		Date of Birth:
Address:		
City, State:		Zip Code:
Tel. #		FAX#:

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

Result:

Billing information

Private citizens: please send check or credit card information.

Send Report to (Full Address)	Bill to (Name of Person/Organization)
As above <input type="checkbox"/>	
Email:	Credit card#: _____ Exp date: _____ CVC#: _____

For Lab staff use only:

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