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	ชื่อเอกสาร : Service Request Form				

### Service Request Form

#### 1. Contact person

Name .....

Tel .....

Mobile .....

E-mail .....

Line ID .....

#### 2. Testing Service

- ☐ Cytotoxicity testing (ISO 10993-5)
 ☐ Bioburden testing (ISO 11737-1:2018/AMD 1:2021)
- ☐ Hemolysis testing (ASTM F756-17)
 Bioburden Validation (Staff Only) ☐ Test ☐ No Test
- ☐ Skin Irritation testing (ISO 10993-23:2021)
 ☐ Sterility testing (ISO 11737-2)
- ☐ Composition analysis (ASTM F D3516)
- ☐ Agar diffusion (CLSI M02)
 ☐ Broth dilution (CLSI M07)
- ☐ Others .....

Note\* : The Bioburden Validation Test will be conducted according to the discretion of the microbiology testing personnel.

No.	Sample Name	Amount per unit	Quantity	Testing Service (Please Specify)

#### 3. Format of Testing Service


- ☐ Regular Service
 ☐ Fast track Service

\*Regular means that the client will receive the service within 60 days from payment date.

\*\*Fast Track means that the client will receive the service within 14 days from payment date.

#### 4. Details of Sample

- 4.1 Name: .....
- 4.2 Product Description : ☐ Solution ☐ Powder/Pellets/Drug ☐ Film/Sheet/Tube ☐ Fiber / Porous / Textiles
- ☐ Solid (Select : Rubber / Polymer / Foam) ☐ Others (specify).....
- 4.3 Product Properties : ☐ Absorption value.....(ml./sample)
- ☐ Soluble (Select : Filterable / Not Filterable) ☐ Insoluble
- 4.4 Type of Sample: ☐ Medical Device ☐ Others (please specify) .....
- 4.5 Other testing methods beyond those prescribed by the laboratory (if any)
- ☐ No ☐ Yes (please specify) .....
- 4.6 Condition of Sample: ☐ Normal ☐ Abnormal ☐ Others (please specify) .....
- Is the Sample stored in proper packaging? ☐ Appropriate ☐ Inappropriate (please specify) .....
- 4.7 Storage condition: .....

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**Note \*\*** No need to sterile for Bioburden testing and Bioburden validation

Additional Notes: .....

**5. Objective**

☐ General information
 ☐ Research
 ☐ Others .....

**6. Through which channel did you learn about the laboratory?**

☐ Personnel of the Laboratory/University
 ☐ Recommendation
 ☐ Facebook
 ☐ Website
 ☐ LinkedIn

☐ Others .....

*Note : The laboratory will send the test report by mail within 3 business days from the date stamped on the document.*

Sender .....


(.....)

Date.....

Receiver .....

(.....)

Date.....

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#### Amount for testing

Test	Surface Area	Weight	Amount
1. Cytotoxicity testing	$\geq 200 \text{ cm}^2$	$\geq 10 \text{ g}$	
2. Hemolysis testing	$\geq 500 \text{ cm}^2$	$\geq 30 \text{ g}$	
3. Composition analysis	$\geq 200 \text{ cm}^2$	$\geq 10 \text{ g}$	
3. Composition analysis	$\geq 200 \text{ cm}^2$	$\geq 10 \text{ g}$	
5. Microbiology testing			
5.1 Bioburden testing			$\geq 6 \text{ EA}$
5.2 Bioburden validation			$\geq 10 \text{ EA}$
5.3 Sterility Testing			$\geq 6 \text{ EA}$
5.4 Antibacterial susceptibility testing			
5.4.1 Agar diffusion method		$\geq 10 \text{ EA}$	
5.4.2 Broth dilution method		$\geq 10 \text{ ml}$	

#### For the Laboratory Supervisor

##### 1. Testing Instruments

☐ Is prepared because...

☐ Good condition

☐ Calibrated

☐ Is not prepared because...

☐ Not Calibrated

☐ Instruments have problem / broken

☐ Work overload

##### 2. Clarity of the Service Requested

☐ The request is clear

☐ The request is unclear

##### 3. Staff

☐ Capable because...

☐ Underwent training

☐ Was already assigned the testing position

☐ Incapable because...

☐ Has not performed this test before

☐ Has not undergone training

☐ Has not been assigned the testing position

##### 4. Quantity of Task

☐ Capable of accepting the request

☐ Capable of accepting the request but may complete slower than usual

☐ Incapable of accepting the request due to an immense backlog

##### Conclusion

☐ Ready

☐ Not Ready

##### Notes:

.....  
 .....

Signed ..... Reviewer

(.....)

Laboratory Supervisor

Date.....

Signed ..... Acknowledged

(.....)

Laboratory Manager

Date.....