


ANGIOGENESIS SERVICE ORDER FORM

 **Allied Biotech, Inc**
10075 Tyler Place, Suite 19
Ijamsville, MD 21754
Tel: (301) 874-0495
Fax: (240) 465-5802
www.alliedbiotechinc.com

QUOTATION # _____

CUSTOMER INFO	BILLING INFO
NAME _____	METHOD OF PAYMENT <input type="checkbox"/> PURCHASE ORDER
POSITION _____	<input type="checkbox"/> CREDIT CARD
ADDRESS _____	P.O. NUMBER _____
_____	BILLING ADDRESS _____
_____	_____
PHONE _____	CONTACT NAME _____
FAX _____	PHONE _____
EMAIL _____	FAX _____

SAMPLE TYPE culture supernatant tissue extract cell lysis serum other: _____

NUMBER OF SAMPLES _____ SAMPLE VOLUME _____ (40µl minimum, 80-100µl recommended)

HUMAN ANGIOGENESIS MARKERS TO DETECT:

<input type="checkbox"/> EGF-HB	<input type="checkbox"/> TIMP-1	<input type="checkbox"/> TIMP-2	<input type="checkbox"/> IP-10	<input type="checkbox"/> PDGF-BB
<input type="checkbox"/> KGF	<input type="checkbox"/> Angiogenin	<input type="checkbox"/> Angiopoietin-1	<input type="checkbox"/> Angiopoietin-2	<input type="checkbox"/> VEGF-A
<input type="checkbox"/> VEGF-D	<input type="checkbox"/> ICAM-1	<input type="checkbox"/> FGF-Basic	<input type="checkbox"/> HGF	

NOTE: WE DO NOT SERVICE INFECTIOUS SAMPLES!

SHIPPING: Please ship samples on dry ice by overnight delivery service on any day except Friday
Please email to order@alliedbiotechinc.com to notify on what date the samples were shipped

SHIPPING ADDRESS: **Allied Biotech Inc.**
10075 Tyler Place, Suite 19
Ijamsville, MD 21754

SHIPPING DATE _____/_____/_____

For Allied Biotech Inc. staff only:	
RECEIVED ON _____	
CONDITION _____	
COMPLETED ON _____	
REPORT EMAILED ON _____	
CUSTOMER ID # _____	Rep _____