


CARDIOVASCULAR ARRAY 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 _____
PHONE _____	BILLING ADDRESS _____ _____ _____
FAX _____	CONTACT NAME _____
EMAIL _____	PHONE _____
	FAX _____

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

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

MARKERS TO DETECT:

Array I

Array II

<input type="checkbox"/> IL-1B <input type="checkbox"/> IL-4 <input type="checkbox"/> IL-5 <input type="checkbox"/> IL-6 <input type="checkbox"/> IL-8 <input type="checkbox"/> IL-10 <input type="checkbox"/> IL-13 <input type="checkbox"/> pro-BNP <input type="checkbox"/> CKMB <input type="checkbox"/> TNF-α <input type="checkbox"/> CD-40L <input type="checkbox"/> INF-γ <input type="checkbox"/> cTnI <input type="checkbox"/> FABP	<input type="checkbox"/> CRP <input type="checkbox"/> MMP-9 <input type="checkbox"/> VCAM-1
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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