


CYTOKINE SERVICE ORDER FORM

 **Allied Biotech, Inc**
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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)

CYTOKINES TO DETECT:

Mouse

- IL-1B IL-2 IL-4 IL-5 IL-6
 IL-10 IL-13 GM-CSF IFN-g
 MCP-1 TNF-a VEGF
 IL-12(p40) IL-12 (p70)

Human

- IL-1B IL-2 IL-4 IL-5 IL-6
 IL-8 IL-10 IL-13 IFN-g IP-10
 MIP-1B TNF-a IL-12 (p40)
 IL-12 (p70)

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 info@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 # _____