Verification Isolate Request Form and Material Transfer Agreement

If you would like to obtain these isolates for the purposes of MIC or disk verification, please complete both pages (credit card authorization form is optional), sign and return by fax:1-440-835-5786 or email:info@labspec.org

Requesting Laboratory (RECIPIENT); TO BE COMPLETED BY RECIPIENT:

Contact and Shipping Information

Contact Name*:	
Institution*:	
Shipping Address 1*:	
Shipping Address 2:	
City, State*:	
Zip Code*:	
Phone*:	
Fax:	
Email:	
FedEx or UPS*, **:	
Shipping Account #*, **:	

Billing Information

Contact Name*:	
Institution*:	
Shipping Address 1*:	
Shipping Address 2:	
City, State*:	
Zip Code*:	
Phone*:	
Fax:	
Email:	
PO Number or CC form*, **:	

***REQUIRED FIELDS**

Please note that a shipping account, purchase order number **or completed credit card form MUST be provided for billing purposes UNLESS the isolates requested price per set is marked No charge (N/C).

Antimicrobial Agents	Catalog No.	# of strains in set	Price per set	Check to request Set	Check to request reading guides*		
					BMD	DISK	MTS
Ceftazidime/Avibactam (AVYCAZ™)	CA30	30	$300		N/A	N/A	N/A
Cefiderocol (FETROJA™) – Gram negative (including 8 *P. aeruginosa*)	FDC30	30	N/C		N/A		N/A
Cefiderocol – *A. baumannii* & *S. maltophilia*	FDC10	10	N/C		N/A		N/A
Cefiderocol – 10 *P. aeruginosa* (**For gradient strip testing, includes 8 PA from gram negative panel**)	FDC10PA	10	N/C		N/A	N/A	N/A
Ceftolozane/Tazobactam (ZERBAXA™)	CT30	30	$300		N/A	N/A	N/A
Dalbavancin (DALVANCE™)	DAL30	30	$300		N/A	N/A	N/A
Delafloxacin (BAXDELA™) – Gram negative	DLX GN30	30	$300		N/A	N/A	N/A
Delafloxacin (BAXDELA™) – Gram positive	DLX GP30	30	$300		N/A	N/A	N/A
Meropenem/Vaborbactam (VABOMERE™)	MV30	30	$300		N/A		
Meropenem/Vaborbactam – addition of a new drug using an existing method	MV10	10	$100		N/A		
Minocycline – *Stenotrophomonas maltophilia*	MIN10	10	$100			N/A	N/A
Omadacycline (NUZYRA™) – Gram negative	OMC GN30	30	$300				
Omadacycline (NUZYRA™) – Gram positive	OMC GP30	30	$300				
Omadacycline (NUZYRA™) – Fastidious	OMC FST30	30	$300			N/A	
Plazomicin (ZEMDRI™)	PLZ30	30	$300		N/A	N/A	N/A

*Requested reading guides are available at no additional cost. N/C = No charge

By requesting the ISOLATES and signing this form, the RECIPIENT acknowledges and agrees to the following terms and conditions:

1. The RECIPIENT is qualified to receive and properly handle the ISOLATES and agrees to follow all relevant safety and government regulations is the use of the isolates.
2. The RECIPIENT agrees that the ISOLATES will be used exclusively for verification of MIC and/or disk testing methods.
3. The RECIPIENT agrees that the ISOLATES will not be transferred to anyone else outside the RECIPIENT organization.
4. The provision of the ISOLATES is not contingent upon, nor intended to serve as an inducement or reward for, any past or future purchases of any product or service.
5. The ISOLATES delivered pursuant to this AGREEMENT are understood to be experimental in nature and may have hazardous properties. LSI MAKES NO REPRESENTATIONS AND EXTENDS NO WARRANTIES OF ANY KIND, EITHER EXPRESSED OR IMPLIED. THERE ARE NO EXPRESS OR IMPLIED WARRANTIES OF MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE, OR THAT THE USE OF THE MATERIAL WILL NOT INFRINGE ANY PATENT, COPYRIGHT, TRADEMARK, OR OTHER PROPRIETARY RIGHTS.
6. To the extent permitted by law, RECIPIENT shall indemnify and to hold LSI harmless from all claims, judgments, liabilities arising out of the RECIPIENT's use for any purpose of the MATERIAL
7. RECIPIENT shall comply with all applicable laws and regulations.
8. RECIPIENT shall not charge or bill any patient or payer (including, but not limited to, Medicare, Medicaid, and commercial insurers) any amount associated with the ISOLATES.

This AGREEMENT is effective upon signature of the authorized official:

SUBMITTING LABORATORY

_____ Date: _____

Signature (sign above)

Name: _____ Title: _____

Credit Card Payment Authorization

Sign and complete this form to authorize Laboratory Specialists, Inc. to make a one-time charge to your credit card listed below. By signing this form, you give us permission to debit your account for the amount owed on or after the indicated date. This is permission for a single transaction only.

I _____ authorize Laboratory Specialists, Inc. to charge the
(Cardholder's Full Name)
credit card account indicated below. This payment is for:

_____
(Description of Goods/Services)

Authorized amount: $_____ (**a 3.5% service charge will be added**)

Cardholder's Billing Information:

Billing Address _____ Phone # _____

City, State _____ Zip Code _____

Email _____

Card Details (please check one):

☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Cardholder's Name _____

Credit Card Number _____

Expiration Date _____ /_____

CVV Code _____

Zip Code _____

I authorize the above-named business to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the goods/services described above and is valid for one (1) time use only. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

SIGNATURE _____ DATE _____
(cardholder)

*__Once payment clears card number will be obscured for security__

PLEASE FAX THIS COMPLETED FORM TO 1-440-835-5786