**REQUEST FOR SERVICES FORM BSOM Histology Core**

**Department of Anatomy & Cell Biology**

**Brody School of Medicine**

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| --- | --- | --- | --- | --- | --- |
| **CUSTOMER INFORMATION** | | | | | |
| REquest number: | |  | | | |
| DATE OF REQUEST: | |  | | | |
| DATE OF COMPLETION: | |  | | | |
| PI NAME: | |  | | | |
| DEPARTMENT: | |  | | | |
| CONTACT ADDRESS: | |  | | | |
| CONTACT PHONE: | |  | | | |
| Administrative Contact: | |  | | | |
| **BILLING INFORMATION** | | | | | |
| INTERNAL TO THE UNIVERSITY | | |  | | |
| FOAP TO BE CHARGED: | | |  | | |
| TYPE OF FUNDING: | | |  | | |
| FEDERAL GRANT OR CONTRACT: | | | YES NO | | |
| EXTERNAL TO THE UNIVERSITY | | |  | | |
| METHOD OF PAYMENT: | | |  | | |
| FEDERAL GRANT OR CONTRACT: | | | YES NO | | |
| **SERVICES REQUESTED** | | | | | |
| DESCRIPTION OF SERVICES REQUESTED:  **Please attach list of samples** | | | | | |
| REQUESTED DATE OF COMPLETION OF SERVICES: | | | | | |
| QTY | DESCRIPTION | | | RATE ($$) | TOTAL ($$) |
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Rates charged will be based upon a published schedule of billing rates.

Payment will be due upon completion of services provided.

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Signature of person requesting services Date