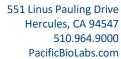


## LABORATORY SERVICE REQUEST (LSR) – Sterility Assurance

CLIENT INFORMATION				
Instructions: Submit the form along with sample(s). Initiation of sa	mple analysis will l	pe delayed if form is not complete.		
PBL Quote Number:	PO Number:	Credit Card to be used for payment 🗌		
Sponsor (send report to):	Invoice To:	Check box if same as sponsor		
Contact Name:	AP Contact Nan	ne:		
Company Name:	Company Name	Company Name:		
Address:	Address:	Address:		
City/State/Zip:	City/State/Zip:	City/State/Zip:		
Country:	Country:	Country:		
Phone:	Invoice To Emai	Invoice To Email:		
Email:	AP Email:	AP Email:		
SERVICE INFORMATION				
Regulatory Treatment: Non-regulatory cGMP C	GLP Rush Se	ervice (will incur a surcharge): YES NO		
☐ Suitability Declined (please specify testing parameters in the ☐ Suitability to be conducted by Pacific BioLabs (Sterile sample unless specified in special instructions)  Method: ☐ USP ☐ AAMI ☐ Other	•			
SAMPLE INFORMATION				
Sample 1 Identification Please use the exact wording you want to appear	ar in the final report.	Quantity of Samples Submitted Please indicate the number of units, volume, and/or weight of samples.		
Lot Number:	Part Number:			
Other Identifier:	Expiration Date:			
Physical Description: Device Solid Liquid G	Gel Other:			
	deline Number:			
Sample 2 Identification Please use the exact wording you want to appear	ar in the final report.	Quantity of Samples Submitted Please indicate the number of units, volume, and/or weight of samples.		
Lot Number:	Part Number:			
Other Identifier:	Expiration Date:			
	Gel Other:			
	deline Number:			





Sample 3 Identification Please use the exact wording you want to appear in the final report.				Quantity of Sample Submitted Please indicate the number of units, volume, and/or weight of samples.		
Lot Number:						
Lot Number: Part Number: Other Identifier: Expiration Date:						
Physical Description: Device Solid Liquid Gel Other:						
*Suitability - PBL Report Number: Guideline Number:						
Sample 4 Identification Please use the exact wording you want to appear in the final report.				Quantity of Samples Submitted Please indicate the number of units, volume, and/or weight of samples.		
Lot Number:			Part Number:			
Other Identifier:			Expiration Date:			
Physical Description: [	Device Solid	] Liquid 🔲 G	el 🗌 Other:			
*Suitability - PBL Report	Number:	Guid	deline Number:			
Storage Condition	Controlled Substance	Hazardous		Sample Disposition		
Room Temperature	□No			Samples will be discarded per PBL SOP unless otherwise indicated.		
2 to 8C	Yes	A fee will apply for disposal of hazardous samples.		Return UNTESTED Samples to Client		
10 to -25C	Schedule:	☐ Not Hazardous		Return TESTED Samples to Client (must be preapproved by PBL)		
60 to -90C	NDC #:	Reactive		If return address is different than Client address above, indicate address in Special Instructions below.		
	Concentration:	☐ Biohazard ☐ Toxic ☐ Other:		Carrier:		
				Account:		
				Dispose in:  municipal waste hazardous waste		
TESTING REQUIRED						
Test Article: Device Parenteral Antibiotic Ophthalmic/Other Non-injectable Preparation Other  Method: Direct Transfer Membrane Filtration						
Purpose of Testing: Quarterly Dose Audit Verification Dose Lot Release Other						
Method of Sterilization	( <b>MUST</b> check one): R	adiation	EO Filtratio	n Steam Other		
Routine Testing						
<ul> <li>Sterility Audit - USP (SCDM and FTM Media)</li> <li>Production Lot Size:</li> <li>Volume per Container:</li> <li>Sterility Audit - AAMI (SCDM Media)</li> <li>□ Biological Indicator Testing − Certificate of Analysis for the lot being sent must be attached</li> </ul>						
OTHER TESTS/SPECIAL INSTRUCTIONS						
Note that samples will be reported separately per lot unless otherwise indicated.						

**TESTING AUTHORIZED BY** (please sign):

DATE:

(Signature and date, or electronic signature, is required for testing to begin; unsigned LSR forms will not be processed)