

Date: _____

CONTACT INFORMATION

Company Name: _____

Contact Name: _____ Title: _____

Email: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Country: _____ Telephone: _____ Fax: _____

Quotation #: _____ Number of Samples: _____

Wavelength Range: _____ nm to _____ nm _____ nm Step Size

SPECIAL INSTRUCTIONS

RETURN INFORMATION

Is the sample to be returned: Service: Overnight 2nd Day Ground

Shipping Account #: *(If Necessary)* _____

PAYMENT INFORMATION - ALL TESTS MUST BE PREPAID

Payment Information: _____ MasterCard Visa Amex Discover

Credit Card #: _____ Expiration: _____

(Call this in if you prefer)