

AFFINITY PURIFICATION REQUISITION

Antibody Core Facility
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PLEASE FILL OUT ONE FORM FOR EACH PURIFICATION REQUESTED:

Contact person: _____ Date: _____

Phone: _____ FAX: _____

Investigator: _____

Department: _____

Authorized Signature: _____

IDR# (REQUIRED!): _____

Sample Descriptor: _____

Cell line (use internal reference number): _____

Please check one box:

Affinity purification of polyclonal antibodies
(Approximately 3ml total sera volume will be purified.)

Affinity purification of antigen
(Approximately 2mg of antigen will be purified.)

Internal use only below this line:

Reference #: _____

Date Purified sample provided to client: _____

Total Charges: _____

Billing Date: _____
