

**MYCOPLASMA TESTING SERVICE
CENTRAL CELL SERVICE, ROOM NB1-38
TEL # X45814, FAX # X50515**

REQUEST FOR MYCOPLASMA TESTING / ERADICATION

Name _____

Principal Investigator _____

Department and MailCode _____

Activity # _____
(12 digit)

Phone No. _____

Date _____

Description of cells _____
(Brief)

No. of samples _____

Type of service _____ Mycoplasma Testing _____ Eradication
(\$52.50/sample)

Total cost to Investigator \$ _____

NOTE:

For Mycoplasma Testing

Cells should be grown for at least 3 days without antibiotics. For **adherent** (scrape cells, and supply a 5ml amount, for **suspensions**, a small tube of approximately 5mls is sufficient.) Take to room NB1- 38.

Results will be sent out in 2 weeks or earlier, if samples are positive.

PRINT CELL NAME CLEARLY ON THE TUBE.

WE WILL NOT ACCEPT CULTURES CONTAINING HIV, BSL3 OR 4 FOR TESTING.