midt
regionmidtjylland

Department of Molecular Medicine
Molecular Diagnostic Laboratory

Aarhus University Hospital

Payment Agreement

Payment information

** required information*

I hereby confirm that:

Inst./Firm/Dept.*: ....

Address*: ....

Zip-code*: .... **City*:** .... **Country*:** ....

International Purchase order (IPO) number* ....

Person reference : ....

will cover the expense of the ordered genetic tests: analysis of the .... **gene(s)***

Cost: ....

Contact information

Name*: ....

E-mail*: ....

Phone*: ....

Date* .... **Signature*** ....

*Please fill in and sign this form and the **Genetic Analysis Requisition Form** and mail them with your samples to:*

Dept. of Molecular Medicine (MOMA)
Aarhus University Hospital
Brendstrupgaardsvej 100, Skejby
8200 Aarhus N
Denmark

Results will only be reported on completion of this form.

Reserved by MDL, request received ________________

Molecular Diagnostic Laboratory /Genetic Analysis Payment Agreement form v1 2011-09-20 katado