Bioassay Sample Form

Last Name: _____ First Name: _____ Middle _____

S.S.N./P.I.N. _____ Organization: _____

Address: _____

Date (dd-mm-yyyy): _____ AWP Number: _____

Sample Media: _____ Urine _____ Fecal _____ Thyroid _____ Lung

_____ Wound _____ WBC _____ Nasal _____ Other (specify): _____

_____

Sample Number: _____ Time (hhmm) _____

Comments: _____

Sample Type: _____ Baseline _____ Routine _____ Post-Work _____ Other _____

Analysis: _____

_____

_____

_____

_____

_____

_____

_____

Time/Date of Sample Collection: Begin: _____ End: _____

Chain of Custody

Relinquished By (Signature)	Date/Time (Relinquished)	Date/Time (Received)	Received By (Signature)

CONTAINS PRIVACY ACT INFORMATION

May-2003

Rev. October 2011