Shelf Life Testing Request Form

Please print, complete, and send this form in with your samples.

Customer Name:	
Company:	
Phone:	
Email:	

Frequency of testing: _____

(daily / weekly / monthly / other)

Storage Temperature:

- ☐ Room Temp (25C)
- ☐ Refrigerated (4C)

Tests to be performed:

- ☐ Total Plate Count (TPC - most common)
- ☐ Total Coliform
- ☐ E. coli
- ☐ Listeria
- ☐ Salmonella
- ☐ Other(s) _____

Special Instructions