Human Cell Authentication Services

Date: ________________

Principal Investigator: ______________________________________

MO Code: ______________

E-mail Address: _____________________________________________
*address will be used to communicate results

Sample names:
1. ________________________  5. ________________________  9. ________________________
2. ________________________  6. ________________________ 10. ________________________
3. ________________________  7. ________________________ 11. ________________________
4. ________________________  8. ________________________ 12. ________________________

Service Costs:

<table>
<thead>
<tr>
<th>Service</th>
<th>Qty</th>
<th>Unit Price</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Human Cell Authentication</td>
<td></td>
<td>$85.00/sample</td>
<td>=</td>
</tr>
</tbody>
</table>

Total

I hereby authorize the DNA Core Facility to begin the requested work. I understand I will be billed monthly for work completed by the DNA Core Facility.

_________________________________  _______________
Signature                                      Date