

SERVICE REQUEST AND INVOICE FORM

Codi: F-SG-018_1

Edició nº 07 Data 15/09/2022

Order date:		ID Expt.: CIT /	Operator:
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USER DATA-INVOICE FORM

CONTACT INFORMATION	
User	Name:
	Telephone number:
	Email:
Internal customer (if applicable)	Research group:
	Group/ Project Principal Investigator:
	Project reference:
	Project cost center:
External customer (if applicable)	Invoicing Manager (position):
	Name:
	Mail:
	Company:
	VAT Number:
INVOICING CONDITIONS:	
Total amount:	
End date and/or report date:	
Invoicing date:	
Comments:	

TERMS OF SERVICE

1. The signing of this application implies that the principal investigator of the project has the Informed Consent Document of the source subject "Law 41/2002 on patient autonomy".
2. The samples will be coded, complying with the current legislation on Data Protection, so that they do not contain identifying data (name and surname, acronym or Clinical History number) of the source subject.
3. The researcher has processed the samples according to the protocol provided and / or validated by IR-HSCSP.
4. Only users with training to use the equipment will be able to access the equipment in its unassisted mode. In this case, the responsible of the platform will give to the user access to the booking calendar.
5. The user will comply with the regulations of the platform with reference to the cleaning of the equipment. If an incident is detected, it will be written in the notebook available next to the equipment.
6. If the cell sorter or LUMINEX are needed to be used, the user will contact the staff of the platform 24 to 96 hours in advance to book the service.
7. If the user has to cancel a reservation in which the technical staff is required, they will notify the staff by email. If it is in unassisted mode, the user will delete the reservation from the relevant calendar.
8. The IR-HSCSP reserves the right to charge a percentage of the total cost of the service in case of cancellation.

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SERVICE INFORMATION

Biosafety questionnaire code:

Type of staining: Antibodies references and company (if first time)

Contaminant agents:

Special conditions for analysis/sorting:

	Unit	Units No.	Price/ unit	Total price
CONVENTIONAL FLOW CYTOMETRY CALIBUR (2 LASERS)				
<input type="checkbox"/> S-048. FACS Calibur unassisted	1 hour			
<input type="checkbox"/> S-049. FACS Calibur staff-assisted	1 hour			
CONVENTIONAL FLOW CYTOMETRY MQ/Canto (3 LASERS)				
<input type="checkbox"/> S-046. MACSQuant unassisted	1 hour			
<input type="checkbox"/> S-047. MACSQuant staff-assisted	1 hour			
FLOW CYTOMETRY CELL SORTER				
<input type="checkbox"/> S-050. Cell Sorter FACSAria	1 hour			
<input type="checkbox"/> S-051. Filters	1 unit			
FLOW CYTOMETRY –AUTOMACS PRO SEPARATOR				
<input type="checkbox"/> S-052. AutoMACS Pro unassisted	1 hour			
<input type="checkbox"/> S-053. AutoMACS Pro staff-assisted	1 hour			
<input type="checkbox"/> S-054. AutoMACS columns	1 unit			

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	Unit	Units No.	Price/ unit	Total price
FLOW CYTOMETRY – LUMINEX				
<input type="checkbox"/> S-055. Luminex unassisted	1 plate			
<input type="checkbox"/> S-138. Luminex unassisted	½ plate			
<input type="checkbox"/> S-056. Luminex staff-assisted	1 plate			
<input type="checkbox"/> S-139. Luminex staff-assisted	½ plate			
OTHERS				
<input type="checkbox"/> S-144 Reagents custom fee	1 unit		1€/u	
<input type="checkbox"/> S-147 Technician hour TSR	1 hour			
<input type="checkbox"/> S-148 Data analysis	1 hour			

TO BE FILLED BY THE FACILITY STAFF

Observations	
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By signing this application form, the customer agrees to follow the internal regulations of the Platform/ Service, to take at all times the precautionary measures according to the identified risks identified for the activity, as well as to communicate any type of incident detected to the technical staff.

Approval of the Entity (Invoicing Manager for the external client)	Approval of the Platform Responsible	Approval of the Research Group/Project Principal Investigator
Name:	Name:	Name:
Signature:	Signature:	Signature:
Date:	Date:	Date: