



Plasmid Manufacturing Services Order Form

Customer Information

Name of Scientist: _____
 Tel Number & Email: _____
 Department/ Room Number: _____
 Company/ Institution: _____
 City, State and Zip: _____

Plasmid Information

Name of the Plasmid: _____
Plasmid Copy Number: High ____ Medium ____ Low ____
 Desired Amount: _____ mgs _____ Liters
 Research Grade: _____ **Pharmaceutical Grade** (Low Endotoxin, Microorganism free): _____
 Antibiotic Resistance: Ampicillin ____ Tetracycline ____ Kanamycin ____ Other ____
 Vector Information: Vector/ Insert Size _____ Restriction Enzyme(s) _____
 Resuspension Buffer: HEPES _____ TE _____ PBS _____ Water _____
 Desired Concentration: mg/ ml _____

Billing Information

Purchase Order Number: _____
 Attn: _____
 Telephone Number: _____
 Company/ Institution: _____
 Street Address: _____
 City, State and Zip: _____
 Credit Card Number:
 Expiration Date:

Card Holders Name: _____

Signature: _____ **Date:** _____

Please print this form, fill and fax to Asthagen for proper processing of your order.

Note: By faxing this order form to Asthagen, Inc. the buyer agrees to pay the amount within 10 days of delivery of products.