Appendix A

Sample Destruction Request Form

Donor Information: (Print Name and Date of Birth)

_____
_____
_____

Please include your phone number so we can contact you if we have questions:

_____

I request that any remaining blood sample that has been extracted to store Cryoprecipitate cells at Medicare Tech Laboratory (Pvt) Ltd, be destroyed immediately.

Signature: _____

Donor or Authorized Legal Representative

Date: _____

Return signed form to:

Medicare Tech Laboratory (Pvt) Ltd.
Customer Services Director
No 43, Bauddhaloka Mw
Gampaha