Appendix A

Sample Destruction Request Form

Donor Information: (Print Name and Date of Birth)

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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

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