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| **In Vitro Testing Sample Submission Form** | | | | |
| **Sponsor Information** | | | | |
| **Quote#:** | **PO#:** | | | |
| **Send Final Report To:** | **Billing Information (if different):** | | | |
| **Company:** | **Company:** | | | |
| **Contact:** | **Contact:** | | | |
| **Address:** | **Address:** | | | |
|  |  | | | |
| **Email:** | **Email:** | | | |
| **Phone:** | **Phone:** | | | |
| **Test Article Information** | | | | |
| **Test Article Name** |  | | | |
| **Test Article Model/Reference ID** |  | | | |
| **Test Article Lot ID** |  | | | |
| **Test Article Expiration Date** |  | | | |
| **Type** | Choose an item. | | | |
| **Test Method Information** | | | | |
| **In Vitro Test Method** | Choose an item. | | | |
| **Extraction Ratio** | Choose an item. | | | |
| **Extraction Conditions** | Choose an item. | | | |
| **Detailed Test Article Information** | | | | |
| **Type of Product Being Tested** | Choose an item. | | | |
| **Sterilization** | Choose an item. | If Other, please describe: | | |
| **Storage Conditions** | Choose an item. | Store in Dark: Choose an item. | | |
| **Device Physical Description:**  **(Use fields appropriate for device)** | Surface Area (cm2): | | | |
| Patient Contacting Surface Area (cm2):  (If different): | | | |
| Dimensions (Overall LxWxH) (cm): | | | |
| Weight (g): | | | |
| Fill Volume (mL): | | | |
| Other: | | | |
| **Intended Clinical Use** |  | | | |
| **Type of Patient Contact** | Direct: | Surface: | Select | |
| External Communicating: | Choose an item. | |
| Implant: | Select | |
| Indirect: | | | |
| If Other, please describe: | | | |
| **Duration of Patient Contact** | Choose an item. | If Permanent, please list the anticipated life span of typical patient: | | |
| Maximum Number of Devices (Patient Exposure) in 1 Day: | | | |
| **Can device be cut?** | Choose an item. | Note: Cutting will destroy test article | | |
| **Final Report Target Date** | Choose an item. | | | |
| If Yes: | Date: ASAP | | Priority/Urgent |
| **Please indicate if study is for submission to regulatory agency:** | FDA:  Notified Body:  Internal Documentation:  Other :  Check all that apply | | | |
| **Are there any known incompatible solvents?** | Yes  No : If yes, please indicate: | | | |
| **Should a feasibility study be performed?** | Yes:  No: | | | |
| **Should a solvent compatibility study be performed?** | Yes:  No: | | | |
| **Is there a potential for Cohort of Concern Compounds Being Present?** | Yes:  No:  If Yes, please list: | | | |
| **Packaging Materials (please list):** |  | | | |
| **Processing Aids, Cleaning Agents, Other Materials used in the Manufacturing and Packaging Process (please list):** |  | | | |
| **Are there safety hazards associated with the device (e.g. sharps, drug products?)** | Yes:  No:  If Yes, please list: | | | |
| **Special Instructions (Preparation, handling, parts to be removed, etc. Attach documentation as needed) If parts are to be removed, please describe which parts of the device should be included in the extraction and represent the patient contact surface area reported above** |  | | | |
| **Study Design: Do you have special extraction conditions (e.g. time and temperature, solvents)?** |  | | | |
| **Please provide the following in table/figure below or as separate document(s):**   * **Description of the Materials of Construction (BOM)** * **Photo and/or Detailed Schematic (Please include scale)** * **Engineering Report** * **Instruction For Use** * **FDA Pre-Submission Feedback** | | | | |

**Test Article(s) Materials of Construction: Test Article(s) Photo(s)/Schematic:**

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| --- | --- | --- | --- |
| Submitter Name |  |  |  |
| Submitter Signature | Date |  |  |

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| --- | --- | --- | --- |
| **Revision Number** | **Description of Change** | **Date (MM/DD/YY)** | **Approved By** |
| 24-0 | New Document | 02/21/2024 | Thomas Reynolds |