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|  | Custom Monoclonal Antibody Request Form Tel: (888) 466-3604; Fax: (925) 215-2184  Email: orders@bosterbio.com |

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| Quotation # |  |  | P.O. # |  |
| Investigator: |  |  | Purchasing Agent: |  |
| Phone: |  |  | Phone: |  |
| Fax: |  |  | Fax: |  |
| Email: |  |  | Email: |  |

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| Project Information | |
| Name of Immunogen: | |
| Format (e.g. liquid, powder, gel, etc.) | |
| Storage Conditions:  -70  -20  2-8 | |
| Number of Vials: | |
| Volume per Vial: | |
| Concentration: | |
| Human/Animal Health Hazard:  Yes  No | |
| Precautions: | |
| Animal Species Requested: | |
| Use Boster Immunization/Bleed Protocol:  Yes  No  Or  Special instructions attached.\*  \* Please note that prior to starting a project, each protocol must be approved by the institution's IACUC and Boster, as it relates to the animal welfare at Boster Biological Technology, Ltd. | |
|  | Mailing Address | |
| Contact |  | |
| Company/Institution |  | |
| Dept./Bldg./Room # |  | |
| Address |  | |
| City, State, Zip |  | |
|  | Shipping Address (if different) | |
| Contact |  | |
| Company/Institution |  | |
| Dept./Bldg./Room # |  | |
| Address |  | |
| City, State, Zip |  | |
|  | Billing Address (if different) | |
| Contact |  | |
| Company/Institution |  | |
| Dept./Bldg./Room # |  | |
| Address |  | |
| City, State, Zip |  | |

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| **Fusion and Clone Selection:** | | | | | | | | | | | |
| **Immunoglobulin Class Wanted:** | | | | IgG | | IgM | | Either | | Other | |
| Special Instructions: | |  | | | | | | | | | |
| **Primary Plates First Assay:** | | | | | | | | | | | |
| Method: |  | | ELISA | | Western | | Other | |  | |  |
| Special Instructions: | |  | | | | | | | | | |
| **Primary Plates Second Assay:** | | | | | | | | | | | |
| Method: |  | | ELISA | | Western | | Other | |  | |  |
| Special Instructions: | |  | | | | | | | | | |
| **Re-clone Plates Assay:** | | | | | | | | | | | |
| Method: |  | | ELISA | | Western | | Other | |  | |  |
| Special Instructions: | |  | | | | | | | | | |

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| **Antibody Production:** | | | |
| **In Vivo (ascites):** 5 Mice per Clone  **In Vitro:**  Tissue Culture, 10 ml Supernatant from Each Clone | | | |
| **Signature:** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Date:** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |