TEST SUBMISSION FORM

Please complete the following details and enclose this form with your sample(s):

PERSONAL DETAILS

Please enter the details of the person(s) being tested:

Title: ___ First name: _____ Last Name: _____ Date of Birth: / /

Postal / Zip Code: _____ Client email (if required):_____

Title: ___ First name: _____ Last Name: _____ Date of Birth: / /

Postal / Zip Code: _____ Client email (if required):_____

Title: ___ First name: _____ Last Name: _____ Date of Birth: / /

Postal / Zip Code: _____ Client email (if required):_____

Title: ___ First name: _____ Last Name: _____ Date of Birth: / /

Postal / Zip Code: _____ Client email (if required):_____

PLEASE PROVIDE AN EMAIL ADDRESS TO RECEIVE TEST RESULTS:

Primary email address: _____

ABOUT YOUR ORDER

Name of Purchaser: _____Transaction Number: _____Date of Purchase: _____

Please clearly state your ORDER NUMBER and POSTCODE / ZIP CODE with your sample(s) for testing.

RETURN THIS COMPLETED FORM WITH YOUR CLEARLY LABELLED HAIR SAMPLES TO YOUR REGIONAL CENTRE:

UK: The Intolerance Testing Group, PO Box 8164, Castle Donington, Derby, DE74 2BZ, United Kingdom
USA: The Allergy Testing Group, 10685-B Hazelhurst Dr. #19057, Houston, TX 77043, United States
CA: Healthy Stuff Online Ltd, 1920 St.Regis Blvd, Dorval QC, H9P 1H6, Canada
AUS: Allergy Test Australia, Suite 196, 10-12 Flushcombe Road, Blacktown, NSW 2148, Australia
NZ: Test Your Intolerance, # 8091, PO Box 13240, Johnsonville, Wellington 6440, New Zealand

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