



ISO/IEC 17025 and ANSI/NCSL Z540-1 accredited
The specialists in ASTM and laboratory thermometers & hydrometers
Members: ASTM API NCSLI ASQ NCWM

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Setting new standards in calibration excellence!

CALIBRATION ORDER FORM FOR VOLUMETRIC GLASSWARE

CUSTOMER INFORMATION

Date: _____

Bill to:

Ship to:

Technical Contact:

Name: _____

Phone: _____

Email: _____

Name on Certificate: _____

Same as above

DEVICE & TESTING INFORMATION

Please check box as appropriate: If the "Same as previous calibration" box is checked, no further test point information is required.

SERIAL NO. _____ TEST POINT(S): Same as previous calibration
 Other (please specify): _____

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 Other (please specify): _____

SERIAL NO. _____ TEST POINT(S): Same as previous calibration
 Other (please specify): _____

RECALIBRATION INTERVAL (per the requirements of your quality system)

Please indicate the calibration interval you wish to appear on the calibration report, for example, "1 YEAR", or specify "NONE" if you do not wish to have a 'Next Due' date appear.

RECALIBRATION INTERVAL: _____

If the interval is left blank, we will insert a 'reasonable and prudent' calibration interval taken from NIST or other authoritative body recommendations.

Note: if we know your recalibration interval, we will contact you approximately one month before the expiration of that interval to remind you recalibration will soon be due.

ANY SPECIAL INSTRUCTIONS OR REQUESTS?

SAFETY INFORMATION

Have any of the devices being submitted for calibration been exposed to radiation, bio-hazardous material or other hazardous contamination?

- No
- Yes *

* If yes, I hereby certify that these device(s) have been decontaminated by approved methods and are safe for handling.

Signature: _____ Title: _____ Date: _____

Print name: _____ Company: _____

PAYMENT OPTIONS (Please select one)

- Corporate Purchase Order # _____ (Please enclose a copy of the PO)
- Visa
- MasterCard
- American Express

Credit Card Number: _____ Expiration Date: _____

Name on Account: _____ Security Code: _____

- UPS C.O.D.

RETURN SHIPMENT (Please select one)

- | | | |
|--|--------------------------------------|------------------|
| <input type="checkbox"/> Standard (UPS Ground) | <input type="checkbox"/> UPS Collect | Acct. No. _____ |
| <input type="checkbox"/> 3 Day (UPS Select) | <input type="checkbox"/> Other | Carrier: _____ |
| <input type="checkbox"/> 2 Day (UPS Blue) | | Acct. No.: _____ |
| <input type="checkbox"/> Overnight (UPS Red) | | |

PLEASE NOTE: A SHIPPING LABEL FOR YOUR USE IS PROVIDED BELOW

Ship To:

ICL CALIBRATION LABORATORIES, INC.
1501 DECKER AVENUE
SUITE 117
STUART, FLORIDA 34994
ATTENTION: CALIBRATION