Little Cherry Disease Response Diagnostic Request

Request No. ______________
Date Received ______________
Invoice No.______________

Submitter Name: ______________________________ Phone number: ______________________

Company Name: ______________________________ Email Address: ______________________

Mailing Address: ______________________________ date mailed: ______________________

______________________________ Total # samples: ______________________

		Sample Information		Virus Tests Requested		Block Location (optional *)		
	Sample Name	Block	Variety	Little cherry virus 2	Western X Phytoplasma	city	latitude	longitude
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

*Optional information for tracking of spread of Little Cherry Disease. Specific information only accessible by WSU Little Cherry Disease Task Force.

Please follow the tissue sampling and preparation instructions on the LCD Response website (http://treefruit.wsu.edu/crop-protection/disease-management/little-cherry-disease/). Send or deliver samples to: Pullman Pest Disease Clinic, 100 Dairy Road, Pullman, WA 99164.

IN OBTAINING THESE SERVICES THE CLIENT AGREES:

I) To pay, **$50.00 per sample**, for said services in full at prices in effect on the date of the submission of this testing request. An invoice for services will be issued by WSU within 30 days of the completion of the tests requested. The Client is responsible for said payments within ten business days of receiving the invoice.

II) That a positive or negative result for a known virus is accurate within the limits of the diagnostic test, state of knowledge of the pathogen, and sensitivity of the platform used.

WSU INTERNAL USE ONLY

Diagnostic tests performed by ______________________________

Tests completed on (date) ______________________________

Results reviewed by/ date ______________________________

Results reported to client on (date) ______________________________