

FAX TO: 01638 724401

ELECTIVE TESTING SAMPLE SUBMISSION FORM

Request no. /12

Please complete in block capitals:

NAME OF TRAINER:	
Address:	
Tel:	Fax:

NAME /CONTACT NO. OF VETERINARY SURGEON:	
Test details:	
Drug for analysis:	
Product name:	Dose:
Date(s) of treatment:	Route of administration:
Date & time of urine sample collection:	
Person collecting sample:	

HORSE RACE DETAILS		
Name	Age:	Sex:
Race entered:		
Race date:		

I request the analysis of the submitted sample for the above drug. I accept the Terms and Conditions for Elective Testing and for the account laid down therein.

Signed (TRAINER)

Date:

Signed (Veterinary surgeon if applicable):

Date:

I confirm that the treatment listed above was prescribed or advised by me.

BHA Approval received from:

Signed:

Date: