

Department Of Diagnostic Medicine / Pathobiology
Scanning Electron Microscopy Work Order

Date: _____

EM # _____

Person Requesting Work: _____

Individual to be billed: _____

Account # _____

Billing Address: _____

<u>Quantity</u>			<u>Total</u>
	<u>Processing</u>		
_____	Base Charge (4 stubs) @	\$108.00	_____
_____	Specimens after first 4 @	\$27.00	_____
_____	Hours (special processing requests) @	\$30.00	_____
	<u>Beamtime</u>		
_____	Hours @	\$96.00	_____
	<u>Micrographs & Phoography</u>		
_____	4" X 5" prints @	\$6.60	_____
	<u>Additional Prints</u>		
_____	1 4" X 5" prints @	\$1.25	_____
_____	5" x 7" prints @	\$2.10	_____
_____	8" x 10" prints @	\$3.50	_____
	_____		_____
	_____		_____

Total = _____