

Custom Competent Cells Service Request Form

1. Customer Information

Client Name _____ Date _____

Company/Institution _____

Email _____ Phone _____

2. Product Information

Strain Name(s) _____ Strain Derivative(s) _____

Antibiotic Resistance Marker (If known) _____

Antibiotic Working Concentration (If known) _____

Required Transformation Efficiency _____ Recovery Media Needed (Y/N) _____

3. Transformation Method

Chemically Competent Cells Electro Competent Cells DirectPlate Chemically Competent Cell

4. Packaging

Format: 1.5 mL twist cap tubes 96-well plate 384-well plate 8x12 strip well rack **Aliquot**

Volume: 10 µL 20 µL 50 µL 100 µL 200 µL 300 µL Custom _____

Quantity _____ **Estimated Usage Frequency and Quantity** _____

5. Timeline

Urgent (1 week) Standard (2 weeks) Requires Extensive R&D (1 month)

Required Delivery Date _____

6. Additional Information (optional)

Specialized Media _____ Positive Control Plasmid _____

Optimal Growing Temperature _____ Doubling Time _____

Special Handling Instructions _____

Any Other Notes _____

Please save the completed form and send it to sales@intactgenomics.com. Thank you for your request