

ChemoGLO™ Site Map Form

WIPE DATE:

Site: _____ Sponsor: _____

Site Address: _____

Street Address _____ Building/Department/Room _____

City _____ State _____ ZIP Code _____

Report to be sent to: _____ Title: _____

Last Name First Name

Phone: () _____ E-mail : _____

Individual conducting wipe sample: _____ Title: _____

Last Name First Name

Phone: () _____ E-mail : _____

Time of Test Start of the Day Closed system transfer device in use?

Middle of the Day Surface cleaned immediately prior to test?

End of the Day Is this a re-wipe?

Cleaning Product Used: _____

Check box for drugs to be analyzed

Doses per Month	YES	Doses per Month	Yes	Doses per Month	Yes
Docetaxel	_____ <input type="checkbox"/>	Busulfan	_____ <input type="checkbox"/>	Gemcitabine	_____ <input type="checkbox"/>
Paclitaxel	_____ <input type="checkbox"/>	Doxorubicin	_____ <input type="checkbox"/>	Mitomycin C	_____ <input type="checkbox"/>
5-Fluorouracil	_____ <input type="checkbox"/>	Daunorubicin	_____ <input type="checkbox"/>	5-Azacytidine	_____ <input type="checkbox"/>
Cyclophosphamide	_____ <input type="checkbox"/>	Cytarabine	_____ <input type="checkbox"/>		
Ifosfamide	_____ <input type="checkbox"/>	Etoposide	_____ <input type="checkbox"/>		
Methotrexate	_____ <input type="checkbox"/>	Vincristine	_____ <input type="checkbox"/>		
Platinum Analogues*	_____ <input type="checkbox"/>	Irinotecan	_____ <input type="checkbox"/>		

* If requesting platinum analogues, indicate the type of material wiped (e.g. plastic, steel, etc.)

Wipe Area ID	Location Description*	Department	Comment
# 1			
# 2			
# 3			
# 4			
# 5			
# 6			