

ChemoGLO™ Site Map Form

Site:		Sponsor:		Wipe Date:	
Site Address:					
	Street Address	Building/Department/Room			
	City	State	ZIP Code		
Report to be sent to:					
	Last Name	First Name	Title		
Phone:	()	E-mail :			
Individual conducting wipe sample:					
	Last Name	First Name	Title		
Phone:	()	E-mail :			
Time of Test	<input type="checkbox"/> Start of the Day	Closed system transfer device in use?		<input type="checkbox"/>	
	<input type="checkbox"/> Middle of the Day	Surface cleaned immediately prior to test?		<input type="checkbox"/>	
	<input type="checkbox"/> End of the Day	Is this a re-wipe?		<input type="checkbox"/>	
Cleaning Product Used:					
Check box for drugs to be analyzed					
Yes	Doses per Month	Yes	Doses per Month	Yes	Doses per Month
<input type="checkbox"/>	Docetaxel	<input type="checkbox"/>	Daunorubicin	<input type="checkbox"/>	Estradiol
<input type="checkbox"/>	Paclitaxel	<input type="checkbox"/>	Cytarabine	<input type="checkbox"/>	Estriol
<input type="checkbox"/>	5-Fluorouracil	<input type="checkbox"/>	Etoposide	<input type="checkbox"/>	Estrone
<input type="checkbox"/>	Cyclophosphamide	<input type="checkbox"/>	Vincristine	<input type="checkbox"/>	Progesterone
<input type="checkbox"/>	Ifosfamide	<input type="checkbox"/>	Irinotecan	<input type="checkbox"/>	Testosterone
<input type="checkbox"/>	Mexotrexate	<input type="checkbox"/>	Gemcitabine	<input type="checkbox"/>	Testosterone Enanthate
<input type="checkbox"/>	Busulfan	<input type="checkbox"/>	Mitomycin C	<input type="checkbox"/>	Testosterone Propionate
<input type="checkbox"/>	Doxorubicin	<input type="checkbox"/>	5-Azacytidine		
<input type="checkbox"/>	Platinum Analogues*_____	* If requesting platinum analogues, indicate the type of material wiped in Comments below (e.g. plastic, steel, etc.)			
Wipe Area	Location Description		Department	Comment*	
# 1					
# 2					
# 3					
# 4					
# 5					
# 6					

Submit the completed Site Map Form to:
 Cara Zamboni
cara@chemoglo.com