

## Payment Agreement

### Payment information

**I hereby confirm that:**

*\* required information*

**Inst./Firm/Dept.\*:** .....

**Address\*:** .....

**Zip-code\*:** ..... **City\*:** ..... **Country\*:** .....

**International Purchase order (IPO) number\*** .....

**Person reference :** .....

**will cover the expense of the ordered genetic tests: analysis of the** ..... **gene(s)\***

**Cost:** .....

### Contact information

**Name\*:** .....

**E-mail\*:** .....

**Phone\*:** .....

**Date\*** ..... **Signature\*** .....

Please fill in and sign this form and the **Genetic Analysis Requisition Form** and mail them with your samples to:

**Dept. of Molecular Medicine (MOMA)  
Aarhus University Hospital  
Brendstrupgaardsvej 100, Skejby  
8200 Aarhus N  
Denmark**

*Results will only be reported on completion of this form.*