

Please mail your completed application and check to:

STERILIZATION MONITORING SERVICE

Dept. of Biomedical Sciences
University of Detroit Mercy
8200 West Outer Drive (MB157)
Detroit, MI 48219-3580

If you have any questions regarding the Sterilization Monitoring Service, please call us at (313) 494-6630.

I WISH TO PARTICIPATE IN THE STERILIZATION MONITORING SERVICE FOR **ONE YEAR** AND HAVE A BIOLOGICAL MONITOR SENT TO ME ON A MONTHLY BASIS.

Signature: _____

Practitioner's Name: _____

Address: _____

City, State, Zip: _____

Telephone Number:

FAX: _____

EMAIL: _____

Please indicate the **TYPE** of service you desire and HOW MANY of each type of sterilizer your office uses. A biological monitor will be sent for each sterilizer indicated. **Please enclose a check for proper amount.**

___ MONTHLY SERVICE

___ AUTOCLAVE

___ UNSATURATED
CHEMICAL VAPOR

___ WEEKLY SERVICE

___ DRY HEAT

A certificate of membership will be sent to you upon request. If you desire a certificate, please **PRINT** your name **EXACTLY** as you wish it to be printed on the certificate.

NAME ON CERTIFICATE: _____