

SAMPLE SUBMISSION FORM

Please fill out both pages of the Sample Submission Form and send the completed form along with your sample(s) to **216 Congers Road Building 1, New City, New York 10956** to the attention of the **Sample Submission Department**.

CLIENT INFORMATION:

Company Name:

Contact Name:

Address:

Email:

City:

Phone:

State:

Postal Code:

Country:

SAMPLE DESCRIPTION:

Please provide the description to be used in the report. Include a unique identifying number (Lot, Batch, Formula or Study)
Please include only one product per submission form.

QTY:

SPF TESTING:

* 100 grams requested

- | | |
|--|---|
| <input type="checkbox"/> FDA
<input type="checkbox"/> Static
<input type="checkbox"/> Water Resistant 40 Minute
<input type="checkbox"/> Water Resistant 80 Minute
<input type="checkbox"/> AS/NZ Australian/ New Zealand
<input type="checkbox"/> Static
<input type="checkbox"/> Water Resistant: _____ Minute | <input type="checkbox"/> SPF ISO 24444 International Standard
<input type="checkbox"/> Static
<input type="checkbox"/> COLIPA European/ Global Harmonization/ International
<input type="checkbox"/> Static
<input type="checkbox"/> Water Resistant
<input type="checkbox"/> Very Water Resistant |
|--|---|
- Panel Size: 1 subject 2 subjects 3 subjects 5 subjects 10 subjects

Please provide the expected SPF value: _____

IN-VITRO UVA TESTING:

* 100 grams requested

- | | |
|--|--|
| <input type="checkbox"/> FDA Critical Wavelength
<input type="checkbox"/> COLIPA European/ International
Please provide the expected SPF value: _____
<input type="checkbox"/> Boots Star Rating System | <input type="checkbox"/> UVA ISO 24443 International Standard
Please provide the measured SPF static value: _____
<input type="checkbox"/> AS/NZ Australian/ New Zealand
Please provide the measured SPF static or water resistant value: _____ |
|--|--|

IN-VIVO UVA TESTING:

* 100 grams requested

- UVA ISO 24442 International Standard
- Panel Size: 1 subject 2 subjects 3 subjects 5 subjects 10 subjects

Please provide the expected PFA value: _____

INFRARED TESTING:

* 100 grams requested

- In-vitro IRPF
 In-vivo IR
 Panel Size: _____ Subject(s)

Please contact us to discuss specific or unique protocol needs.

Official Use Only



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SAMPLE SUBMISSION FORM

SAFETY TESTING:

- | | | |
|---|--|--|
| <input type="checkbox"/> RIPT
<input type="checkbox"/> 24 Hour Patch
<input type="checkbox"/> 48 Hour Patch
Panel Size:
<input type="checkbox"/> 50 subjects
<input type="checkbox"/> 100 subjects
<input type="checkbox"/> 200 subjects
<i>* RIPT - 400 grams requested</i>
<i>* 24hr/48hr - 100 grams requested</i> | <input type="checkbox"/> Cumulative Patch
Panel Size:
<input type="checkbox"/> 20 subjects
<i>* 200 grams requested</i>
<input type="checkbox"/> PhotoToxicity
Panel Size:
<input type="checkbox"/> 20 subjects
<i>* 100 grams requested</i>
Sensitive Skin _____% of subjects | <input type="checkbox"/> Comedogenicity
Panel Size:
<input type="checkbox"/> 6 subjects
<i>* 100 grams requested</i>
<input type="checkbox"/> PhotoAllergy Maximization
Panel Size:
<input type="checkbox"/> 25 subjects
<i>* 200 grams requested</i> |
|---|--|--|

For the testing requested above please fill out the applicable fields listed below:

- | | | |
|--|---|--|
| Patch Configuration:
<input type="checkbox"/> Occluded
<input type="checkbox"/> Semi-Occluded
<input type="checkbox"/> Open | Dilution:
<input type="checkbox"/> Undiluted
<input type="checkbox"/> Diluted to _____%
<input type="checkbox"/> Distilled water
<input type="checkbox"/> Other _____ | Signature:
<input type="checkbox"/> Dermatologist
<input type="checkbox"/> Pediatrician
<input type="checkbox"/> Gynecologist
<input type="checkbox"/> Plastic Surgeon |
|--|---|--|

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Eye Sting Assay
Panel Size:
<input type="checkbox"/> 5 subjects
<input type="checkbox"/> 10 subjects
<i>* 100 grams requested</i> | <input type="checkbox"/> Facial Sting Assay
Panel Size:
<input type="checkbox"/> 5 subjects
<input type="checkbox"/> 10 subjects
<i>* 100 grams requested</i> | <input type="checkbox"/> Vaginal Irritation**
Panel Size:
<input type="checkbox"/> 5 subjects
<input type="checkbox"/> 10 subjects
<i>** Individual units in sufficient quantities according to use instructions and the duration of the study</i> | <input type="checkbox"/> Ophthalmology**
Panel Size:
<input type="checkbox"/> 30 subjects
<input type="checkbox"/> 60 subjects |
|--|---|--|---|

***Please provide use instructions for Vaginal Irritation/Ophthalmology:* _____

EFFICACY TESTING:

- | | |
|---|--|
| <input type="checkbox"/> Skin Surface Hydration via Corneometer
<input type="checkbox"/> Skin Moisturization - Electroconductivity via Novameter
<input type="checkbox"/> Surface Evaluation of Living Skin (SELS) via Visioscan
<input type="checkbox"/> Skin Elasticity and Firmness via Cutometer
<input type="checkbox"/> Transepidermal Moisture Loss (TEML) via DermaLab Evaporimeter | <input type="checkbox"/> Skin Sebum via Sebumeter
<input type="checkbox"/> Skin Lightening via Chromameter
<input type="checkbox"/> Matched Scientific Photography, MSP™
<input type="checkbox"/> PhotoGrammetrix Analysis, PhGx®
<input type="checkbox"/> Subjective Questionnaire addressing user perceived benefits |
|---|--|

For testing requested above please fill out the fields listed below:

Time Points: _____ Panel Size: _____ Subject(s)

Please provide use instructions: _____

- | | |
|--|--|
| <input type="checkbox"/> Antiperspirant Testing
Test Site: <input type="checkbox"/> Axilla <input type="checkbox"/> Foot <input type="checkbox"/> Other _____
Time Points: <input type="checkbox"/> 1 Hour <input type="checkbox"/> 24 Hours <input type="checkbox"/> 48 Hours <input type="checkbox"/> 72 Hours <input type="checkbox"/> Other _____
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female | <input type="checkbox"/> Deodorant Testing
Panel Size: _____ Subject(s) |
|--|--|

Please contact us to discuss specific or unique protocol needs.

Submitted by/Authorized Signature: _____ Date: _____



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