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Ordering person Myriad Contact/Distributor; NAME, LAST NAME: \_\_\_\_\_

### Customer address (if known)

_____ Name (Recipient)	_____ Last name	_____ Title
_____ Institution / company	_____ Department	
_____ Street	_____ Number / supplement	
_____ City	_____ Zip-code	
_____ Phone-number <small>(A phone number MUST be provided)</small>	_____ E-mail address <small>(An email address MUST be provided)</small>	
_____ Country	_____ Payer-ID <small>(A payer-ID MUST be provided)</small>	

### Delivery address (if different from customer address)

_____ Name (Recipient)	_____ Last name	_____ Title
_____ Institution / company	_____ Department	
_____ Street	_____ Number / supplement	
_____ City	_____ Zip-code	
_____ Phone-number <small>(A phone number MUST be provided)</small>	_____ E-mail address <small>(An email address MUST be provided)</small>	
_____ Country	_____ Payer-ID <small>(A clinical-ID MUST be provided)</small>	



### Product

- BRACAnalysis CDx (European Union and UK only)
- MyRisk PLUS (European Union and UK only)
- MyRisk (Universal Hereditary Cancer, for countries outside US, UK, Japan, European Union)
- Prolaris (for countries outside US and European Union)
- EndoPredict (for countries outside US and European Union)
- MyChoice CDx Plus (for countries in European Union, UK and Israel)
- MyChoice HRD Plus (for countries outside US, UK, Japan, European Union)
- \_\_\_\_\_  
Other US product (i.e. myPath Melanoma etc.)

### # Quantity

_____
_____
_____
_____
_____
_____
_____
_____

### Type

### Language

### Special requirements:

Additional comments: \_\_\_\_\_

### For internal use only / do not fill

Internal article-no.:	Lot-no./opt.	Expiration date/opt.	
<b>Waybill</b>			
	Name	Date	Signature
Order received			
Order received			
Order received			

Feedback or questions: [Testkit@myriadgenetics.eu](mailto:Testkit@myriadgenetics.eu)