

## New Account Application

### About Applicant:

Name (print): \_\_\_\_\_(First) \_\_\_\_\_(Last)

Phone #: \_\_\_\_\_ Fax#: \_\_\_\_\_ E-mail: \_\_\_\_\_

Room # \_\_\_\_\_ Department \_\_\_\_\_ Institution \*: \_\_\_\_\_

Applicant Signature: \_\_\_\_\_

Date: \_\_\_\_\_

### About the Supervising Investigator:

Name (print): \_\_\_\_\_(First) \_\_\_\_\_(Last)

Phone #: \_\_\_\_\_ Fax#: \_\_\_\_\_ E-mail: \_\_\_\_\_

Room # \_\_\_\_\_ Department \_\_\_\_\_ Institution \*: \_\_\_\_\_

Street Name & Number \*: \_\_\_\_\_

City, Province and postal code \*: \_\_\_\_\_

### Billing Information:

Cost Centre / Billing Account#: \_\_\_\_\_ or

Credit Card#: \_\_\_\_\_  VISA  AmExp  MasterCard or  \_\_\_\_\_

Card Holder Name: \_\_\_\_\_ Expire Date \_\_\_\_\_

### Billing Address \*:

\_\_\_\_\_  
\_\_\_\_\_

Supervising Investigator Signature: \_\_\_\_\_

Date: \_\_\_\_\_

*\*Not required for users from Hospital for Sick Children*

*Each person needs to complete this form the first time to request experiment at the facility.*

*Any question to complete this application form, please contact Microarray Facility*

Microarray Facility use only: Date Received: \_\_\_\_/\_\_\_\_/\_\_\_\_ Rec'd by: \_\_\_\_\_