

# AERA SWABBING KIT - ORDER FORM



Complete this form fully and email to AERA Medication Control Person, Dorte Colja, Email: [dortecol@gmail.com](mailto:dortecol@gmail.com)  
Please allow three weeks for delivery of kits.

Open the document on your PC and type directly into the cells and then save.

| DETAILS OF PERSON PLACING THE ORDER |  |
|-------------------------------------|--|
| NAME                                |  |
| ADDRESS                             |  |
| PHONE(S)                            |  |
| EMAIL                               |  |

| DETAILS OF THE EVENT |  |
|----------------------|--|
| NAME OF EVENT        |  |
| LOCATION OF EVENT    |  |
| DATE OF EVENT        |  |

| SWABBING KIT REQUIREMENTS                                                               |  |
|-----------------------------------------------------------------------------------------|--|
| NUMBER OF KITS REQUIRED                                                                 |  |
| NAME OF NOMINATED PERSON WHO IS TO RECEIVE THE KITS (PREFERABLY MCP ACCREDITED)         |  |
| PHYSICAL ADDRESS OF THE NOMINATED PERSON ABOVE TO RECEIVE THE KITS (CANNOT BE A PO BOX) |  |
| LAST POSSIBLE DELIVERY DATE TO THE NOMINATED PERSON                                     |  |