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Date: -

**IN-VITRO TESTING REQUEST FORM****1. Applicant / Investigator Details**

- Name of Applicant:
- Designation / Course:
- Department / Institution:
- Contact Number:
- Email ID:

**2. Project Information**

- Title of the Research Project:
- Type of Study:  
☐ Academic ☐ PhD / M. Pharm / M.Sc ☐ Sponsored / Industry

**3. Sample Details**

- Sample Name / Code:
- Nature of Sample:  
☐ Plant Extract ☐ Pure Compound ☐ Synthetic Drug ☐ formulation ☐ Other: \_\_\_\_\_
- Solvent Used: \_\_\_\_\_ Concentration Range ( $\mu\text{g/mL}$  or  $\mu\text{M}$ ): \_\_\_\_\_
- Quantity Submitted: \_\_\_\_\_ Storage Conditions: \_\_\_\_\_

**4. Analysis Required**

<input type="checkbox"/> Authentication of Plant/Drug	<input type="checkbox"/> Extraction of Plant/Drug	<input type="checkbox"/> Phytochemical Screening
<input type="checkbox"/> Standardization of Plant/Drug	<input type="checkbox"/> Invitro Analysis	

**5. Analytical / Instrumental Analysis**

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**6. In-Vitro Activity**

<input type="checkbox"/> Anti-Cancer	<input type="checkbox"/> Brine Shrimp Lethality	<input type="checkbox"/> Anti-Oxidant	<input type="checkbox"/> Anti-Inflammatory
<input type="checkbox"/> Anti-Diabetic	<input type="checkbox"/> Anti-Microbial	<input type="checkbox"/> Anti-Malarial	<input type="checkbox"/> Anti-HIV
<input type="checkbox"/> Anthelmintic	<input type="checkbox"/> Immunomodulatory	<input type="checkbox"/> CAM Assay	<input type="checkbox"/> Anti-Urolithiasis
<input type="checkbox"/> Lipase Inhibition	<input type="checkbox"/> In-Vitro Wound Healing (Cell Line)	<input type="checkbox"/> In-Vitro Antimitotic	
<input type="checkbox"/> Other: _____			

**7. Declaration**

I hereby confirm that the sample submitted is safe for laboratory handling and the information provided is correct.

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

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

**For Office Use Only**

Received By: \_\_\_\_\_ Approved By: \_\_\_\_\_ Remarks: \_\_\_\_\_