VACU-GAS TREATMENT REQUEST FORM

Customer Name: ______________________ **Customer Purchase Order No.:** ______________________

Customer Address: ______________________

______________________ **Phone No.:** ______________

Contact Person: ______________________ **Fax No.:** ______________

Email Address: ______________________

Type of processing: ☐ Full Cycle (Routine) **Validation:** ☐ Partial Cycle ☐ Half Cycle ☐ Full Cycle ☐ Other: ______________

Cycle No.: ______________

Customer product description: ______________________

Customer batch/lot/shipper No.: ______________________

Quantity Shipped to PSS:
- ☐ Pallet(s): Qty: ______________
- ☐ Case(s): Qty: ______________
- ☐ Other: ______________

Quantity to be processed:
- ☐ Pallet(s): Qty: ______________
- ☐ Case(s): Qty: ______________
- ☐ Other: ______________

Description and nbr. of test samples, if any:

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Courier service: ______________________

Special Instructions, if any:

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Prepared By: ______________________ **Date:** ______________

Retort Run No.: ______________________
(To be filled by PSS)

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