UNIVERSITY OF GEORGIA

Department of Plant Pathology
Tifton campus

Resistant Profile Form

Molecular Diagnostic Laboratory

Shipping Address:
Tifton, CAES Campus,
115 Coastal Way, Tifton, GA 31794
Phone: 229-386-7230
Fax: 229-386-7285
Email: emran.ali@uga.edu

MDL staff only

Received by: _____
Received date: _____
Sample ID #: _____
Processed by: _____
Date completed: _____
Diagnostic fee (Amt): _____
Pmt type: _____

Visit: https://site.caes.uga.edu/alimdl/

Submitter/ Client Information

Submitter name		**Grower Category**	
Address		☐ Commercial (consultant, grower)	
		☐ Homeowner	
Phone no		☐ Golf Course	
Email		☐ UGA Research	
Client name (if different)		☐ Extension	
Address		☐ UGA PDC	DDDI No.
Phone no		☐ Other	

Sample Information

Pathogen for Resistance Profile with Host Plant:			
Type of Sample Sent	☐ Dead Flowers	☐ Dead Leaves	☐ Swab with Spores
	☐ Others:		
Origin of sample (County/state)			
Date Sample taken			
Date of sample submission			

Fungicides Applied (This information may help us determine disease potential)

Fungicide: _____	**Rate:** _____	**Date applied:** _____
Fungicide: _____	**Rate:** _____	**Date applied:** _____
Fungicide: _____	**Rate:** _____	**Date applied:** _____
Fungicide: _____	**Rate:** _____	**Date applied:** _____
Fungicide: _____	**Rate:** _____	**Date applied:** _____
Fungicide: _____	**Rate:** _____	**Date applied:** _____
Fungicide: _____	**Rate:** _____	**Date applied:** _____
Fungicide: _____	**Rate:** _____	**Date applied:** _____

Send result to	☐ Submitter ☐ Client ☐ Third party	**Send result via:**	☐ E-mail ☐ Fax ☐ Standard mail	☐ Phone ☐ Other (please specify)

Payment Information

Please make sure your payment to the MDL for the specific service. The results will only be provided upon receipt of payment. Please contact MDL director about fees prior to sample submission

Payment made by	Send invoice (E-mail/Fax) to:
☐ Check payable to MDL	☐ Submitter
☐ Credit/debit card	☐ Client

Acknowledgement

I hereby agree to pay the appropriate fees for this service. I acknowledge that the accuracy of the assay is dependent on the quality of samples with thorough background information. Poor quality of samples may lead to inaccurate test results.	**Signature:** _____ **Printed name:** _____ **Date:** ***Signature is required for sample processing.**

TEST RESULTS (MDL staff only):
Date Received: _____ **Date of Spore Inoculation:** _____ **Date of Results:** _____

***For more details on sample submission instruction, please go to: https://site.caes.uga.edu/alimdl/submission-forms/**