SOLAR® LIGHT

# SPECTRAL TRANSMISSION TESTING

Date:_____

## CONTACT INFORMATION

Company Name:_____

Contact Name:_____ Title:_____

Email:_____

Street Address:_____

City:_____ State:_____ Zip:_____

Country: _____ Telephone:_____ Fax:_____

Quotation #: _____ Number of Samples:_____

## RADIOMETRIC EVALUATION

Number of UV Tranmission Samples:_____ Wavelength Range 250 – 450 nm

Number of Visible Tranmission Samples:_____ Wavelength Range 400 – 700 nm

## RETURN INFORMATION

Is the sample to be returned: ☐ Service: ☐ Overnight ☐ 2nd Day ☐ Ground

Shipping Account #: *(If Necessary)*_____

Payment Information:_____ ☐ MasterCard ☐ Visa ☐ Amex ☐ Discover

Credit Card #:_____ Expiration:_____ CVV:_____

*(Call this in if you prefer)*

PO #: *(Approval Required)*_____

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