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2<sup>nd</sup> Floor, Suite 2  
Bronx, NY 10461

Email: info@exclusivelabs.com  
Phone: 718.239.2347  
Fax: 718.239.2348

**LEAD DUST WIPE CLEARANCE TESTING  
REQUEST FORM**

Date of this request: \_\_\_\_\_

Purchase Order #: \_\_\_\_\_

Client Name: \_\_\_\_\_

Client Address: \_\_\_\_\_

(STREET)

(CITY)

(STATE)

(ZIP CODE)

Client Phone: \_\_\_\_\_

Client Fax: \_\_\_\_\_

Building's Corporate Name: \_\_\_\_\_

Building Address: \_\_\_\_\_

(STREET)

(CITY)

(STATE)

(ZIP CODE)

Apartment # or Common Areas: \_\_\_\_\_

Superintendent Name: \_\_\_\_\_

Superintendent Phone: \_\_\_\_\_

HPD Violation: No  Yes  (If yes, attach violation with this request form)

Date Work Completed: \_\_\_\_\_

Work Done: Whole Apartment: No  Yes  (If no, fill in details below)

**Please make copies for future use.**

Fax this form to Exclusive Testing Labs, Inc at 718.239.2348 after all necessary information has been filled out.

If you have any questions, please call 718.239.2347

**FOR OFFICE USE ONLY**

File # \_\_\_\_\_

Date \_\_\_\_\_

Status \_\_\_\_\_

Current  New

Date tested \_\_\_\_\_

# of Samples \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Exclusive Testing Labs Inc. is hereby authorized to contact the superintendent/manager with respect to the subject vacant dwelling and perform lead dust wipe clearance testing. The undersigned is authorized to sign on behalf of the client.

Authorized Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

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