

SSD AND WELL TYPE CHAMBER CALIBRATION REQUEST FORM

AERB Approved & NABL Accredited Laboratory (ISO/IEC 17025:2017)

Please complete all sections. Incomplete forms may delay processing.

(Please use separate form for each instrument)

1. Customer Details

- **Organization Name:** _____
- **Contact Person:** _____
- **Address:** _____
- **Phone:** _____ **Email:** _____
- **Date of Request:** ____ / ____ / ____ **GST No:** _____

2. Instrument Details

Instrument Type

- ☐ Well Chamber ☐ Electrometer
☐ Other: _____

Manufacturer

Model Number

Serial Number

Range (Low / Medium / High)

Instrument Condition

- ☐ Working
☐ Not Working: _____

3. Calibration History

- **Previous Calibration Date:** ____ / ____ / ____
- **Previous Certificate No.:** _____
- **Requested Calibration Interval (Default – 3 years):** _____

4. Declarations & Terms

1. **Customer Declaration:** I hereby declare that the instrument submitted for calibration are in the condition as marked above (Working / Not Working). In case the instrument is not working, the reason has been clearly specified.
2. **Terms & Conditions:** Calibration will be performed in accordance with ISO/IEC 17025:2017 methods and procedures (iso.org), NABL accreditation requirements (nabl-india.org), and AERB safety guidelines. Radimage Healthcare reserves the right to refuse calibration of instruments not meeting safety or technical criteria.

Customer Signature/Name: _____

Date: ____ / ____ / ____

Once completed, please attach this form and send the filled document to the respective calibration department email Id for processing.