

HONEY BEE DIAGNOSTIC LAB REQUEST FORM

DATE COLLECTED _____ / _____ / _____ DATE SHIPPED _____ / _____ / _____

SHIPMENT TYPE First Class Priority Express _____ TRACKING NO. _____

BEEKEEPER Name _____ Primary Phone (_____) _____ - _____

Address _____ City _____ State _____ Zip Code _____

Email _____ County _____

APIARY Name _____ Same as above

Address _____ City _____ State _____ Zip Code _____

SAMPLE INFORMATION

Colony _____ Sample# _____ Type: brood adults honey pollen other _____

Colony _____ Sample# _____ Type: brood adults honey pollen other _____

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DIAGNOSTIC LAB ANALYSIS REQUESTED

American Foulbrood (AFB) _____ European Foulbrood (EFB) _____

Nosema spp. _____ Africanized Honey Bee (AHB) _____

Varroa Mites _____ Tracheal Mites _____

Virus Screen _____ Pesticide Screen _____

Honey/Pollen Identification _____ Small Hive Beetle (SHB) _____

Other _____

Notes _____

SUBMITTED BY (SIGNATURE) _____ **DATE** _____

PRINTED NAME _____ **Title** _____

EMAIL _____

Adapted from the Massachusetts Dept. of Agricultural Resources Apiary Program by UMass Extension
Produced as part of the Massachusetts Bee-Vet Project, September 2021. For more info visit:
<https://ag.umass.edu/resources/pollinators/resources-for-veterinarians>

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