**THE NCBS/INSTEM X-RAY FACILITY**

**USAGE FORM: RIGAKU XRD MACHINE**

TO BE FILLED BY ALL USERS

DATE:

NAME :

DESIGNATION:

LAB/DEPARTMENT:

ADDRESS:

MOBILE: EMAIL:

DATE & TIME OF BOOKING : FROM

TO

PRINCIPAL INVESTIGATOR:

NUMBER OF CRYSTALS:

SIGNATURE SIGNATURE OF PI WITH DATE

Remarks if any: