LIFESPAN – RHODE ISLAND HOSPITAL

TUMOR BANK

SERVICE REQUEST FORM

#	TISSUE TYPE (ORGAN)	TUMOR (SPECIFY TYPE)	Snap frozen tumor tissue vials*	Snap frozen normal tissue vials*	OCT embedded tumor tissue	OCT embedded normal tissue
1.						
2.						
3.						
4.						
5.						

*please indicate if matched samples are required

FEE: per specimen: $25 (COBRE) $50 (non-COBRE)

PLEASE ENCLOSE THE FOLLOWING:

IRB APPROVAL LETTER (copy)

BRIEF RESEARCH SUMMARY

DOCUMENTATION of

SAFETY/UNIVERSAL PRECAUTIONS TRAINING

For more information, please contact:

Trish Meitner, Ph.D. at 444-8482, Aldrich-600A.

I agree to the above stated fee schedule.

Applicable charges should be billed to the following account:

Name:____

Department:____

Date:____

Cost Center to be Billed:___________________________________

Principal Investigator Name:_________________________