## TISSUE BANK

**SERVICE REQUEST FORM**

<table>
<thead>
<tr>
<th>#</th>
<th>TISSUE TYPE (ORGAN)</th>
<th>TUMOR (SPECIFY TYPE)</th>
<th>Snap frozen tumor tissue vials*</th>
<th>Snap frozen normal tissue vials*</th>
<th>OCT embedded tumor tissue</th>
<th>OCT embedded normal tissue</th>
<th>Other</th>
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</table>

*please indicate if matched samples are required

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

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**PLEASE ENCLOSE THE FOLLOWING:**

- IRB APPROVAL LETTER (copy)
- BRIEF RESEARCH SUMMARY
- DOCUMENTATION of
  - SAFETY/UNIVERSAL PRECAUTIONS TRAINING

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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:__________________

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For more information, please contact:

Ardem Elmayan at 444-5849, Aldrich-600A.