COBRE CENTER FOR CANCER RESEARCH DEVELOPMENT

LIFESPAN – RHODE ISLAND HOSPITAL

TISSUE 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	Other
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

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:_____

For more information, please contact:
Ardem Elmayan at 444-5849, Aldrich-600A.