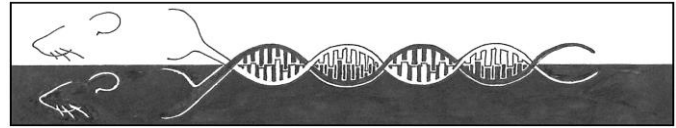


Transgenic and Stem Cells Service Unit



CRYOPRESERVATION SERVICE REQUEST

Date _____
Principal Investigator's Name _____
Name of Person Conducting Experiment _____
Department _____
Institution _____
Lab Contact _____ Lab Contact E-Mail _____
Lab Contact Telephone _____
Billing Contact _____ Billing Contact E-Mail _____
Billing Telephone _____ Billing Fax _____
Billing Address _____

Gene/ Mouse Line Name _____ IMM Abbreviated Name _____
Type of Service: Embryo Cryopreservation ___ Sperm Cryopreservation ___
Mouse Background Strain _____
PO (or account # for UTHealth) for project: _____

Principal Investigator's signature _____ Date _____
Dr. Zsigmond's signature _____ Date _____

INSTRUCTIONS

Fill form out and fax or mail it to:

University of Texas Health Science Center- Houston
The Brown Foundation Institute of Molecular Medicine,
Transgenic and Stem Cells Service Unit
c/o Aleksey Domozhirev
1825 Pressler Street, Suite 611, Houston, TX 77030
Telephone: (713) 500-2452 **Fax:** (713) 500-2208 **E-Mail:** transgenic@uth.tmc.edu