Dear CellNetix Customer,

Thank you for your research request. Please complete the information below and fax the form and any additional paperwork to 206-576-6711. You will receive a response within 3-5 business days.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Name of Study** |  | | | | ***Date****:* | Click or tap to enter a date | |
|  | | | | | | | |
| **Company/Institution:** | |  | | | | | |
| **Study Description:** | | Enter details and/or attach separately | | | | | |
| **IRB Approval:** | | No  Yes  N/A: | **Approval Date:** | **Patient Consent Forms:**  **No**  **Yes** | | | |
| **Scope of Services Needed:** | |  | | | | | |
| **Technical**  **(Ex: create slides, stains, curls)** | | **No**  **Yes** | **If yes, specify:** |  | | | |
| **Professional**  ***(Ex: case review, tumor assessment, tissue procurement)*** | | **No**  **Yes** | **If yes, specify:** |  | | | |
| **Material only request**  **(Ex: existing block or slide pull)** | | **No**  **Yes** | **If yes, specify:** |  | | | |
| **Research Contact Information:** | | **Name:** |  | | | | |
| **Email:** |  | | | | |
| **Phone:** |  | | | | |
| ***Shipping Information:*** | | **Address** |  | | | **City** |  |
| **State** |  | | | **Zip** |  |
| ***Reimbursement or Billing Information:*** | | **Funded** | **No  Yes** | | | **Funding detail** |  |
| **Name** |  | | | **Phone** |  |
| **Address** |  | | | **City** |  |
| **State** |  | | | **Zip** |  |
|  | | | | | | | |

***\*Special Note\* —*** Requests that may exhaust the remainder of the tissue block will not be approved.