



# CCHMC COMPREHENSIVE MOUSE AND CANCER CORE Transplant Request Form

Animal Core Office Use

Received : \_\_\_\_\_

**Please provide request at least 72 business hours in advance of requested service date.  
Services will not be provided without a completed request form.**

TO REQUEST ANIMAL TRANSPLANT SERVICES, COMPLETE THIS FORM. UPON COMPLETION THIS FORM MAY BE EMAILED TO JEFF BAILEY (JEFF.BAILEY@CCHMC.ORG); FAXED (513-636-3768) OR DELIVERED TO CHR# 7502, CINCINNATI CHILDREN'S HOSPITAL MEDICAL CENTER, 3333 BURNET AVE., CINCINNATI, OH 45229-3039.  
FOR QUESTIONS, CONTACT VICTORIA SUMMEY OR JEFF BAILEY (513-636-5879).

**1. Contact Information**

|                           |                         |
|---------------------------|-------------------------|
| a. Principal Investigator | d. Division/Institution |
| b. Primary Lab Contact    | e. Office Location      |
| c. Phone/Fax              | f. E-mail               |

**2. Services Requested**

Animal Strain: \_\_\_\_\_  
 Description of Experiment: \_\_\_\_\_

| Requested Service              | Date Service Required | Number of Animals | *Charge per Animal    | Total Service Charge | Completed (Tech/Date) | Comments |
|--------------------------------|-----------------------|-------------------|-----------------------|----------------------|-----------------------|----------|
| Irradiation (Animal)           |                       |                   | \$5.00                |                      |                       |          |
| Irradiation (Cells)            |                       |                   | \$35.00 per Treatment |                      |                       |          |
| Injections (TV/IP) per inject. |                       |                   | \$4.00                |                      |                       |          |
| IF Injection/Aspirate          |                       |                   | \$6.50/\$8.00         |                      |                       |          |
| Bleeds (Tail/RO)               |                       |                   | \$4.50/\$5.00         |                      |                       |          |
| Bone Marrow Harvest            |                       |                   | \$5.00                |                      |                       |          |
| Hourly Support                 |                       |                   | \$50.00               |                      |                       |          |

\*Charge for service is for normal hours of operation (Monday-Friday 8:30 a.m. to 6:00 p.m. excluding CCHMC holidays). Additional fees (1.5 fold) will have to be charged for off hour services. A \$25.00 transportation and set up fee will be added to all services done at a University of Cincinnati facility.

**3. IACUC**

CCHMC IACUC Protocol number \_\_\_\_\_  
 All procedures requested to be performed by the core are specifically stated and approved in your protocol.  
 Signature \_\_\_\_\_

**4. Billing**

PROVIDE APPLICABLE ACCOUNT INFORMATION AS INDICATED IN THE BOX ON THE RIGHT. FORM MUST BE SIGNED BY AN APPROVER

**AUTHORIZED SIGNATURE** \_\_\_\_\_

|                      |                      |                       |                            |
|----------------------|----------------------|-----------------------|----------------------------|
| <b>GL BU *</b>       | <b>FUND *</b>        | <b>ACCOUNT *</b>      | <b>DEPARTMENT *</b>        |
| _ _ _ _              | _ _ _ _              | 6 6 6 3 5 0 _ _ _ _   | _ _ _ _ _ _ _ _ _          |
| <b>PROJECT BU **</b> | <b>PROJECT ID **</b> | <b>ACTIVITY ID **</b> | <b>BUDGET REFERENCE **</b> |
| _ _ _ _              | _ _ _ _              | _ _ _ _               | _ _ _ _                    |

\* MANDATORY FIELDS FOR ALL PAYMENTS  
 \*\* MANDATORY FOR GRANTS, CONTRACTS & INDUSTRY AGREEMENTS

**Core Use ONLY**

**Total Charge:** \_\_\_\_\_