

SOUTHWESTERN

THE UNIVERSITY OF TEXAS
SOUTHWESTERN MEDICAL CENTER
AT DALLAS

**TRANSGENIC TECHNOLOGY
CENTER**



**Request Form
Cryopreservation of Ovaries**

Date: _____

IDR: _____

PI: _____ **E-mail:** _____

Contact: _____ **E-mail:** _____

Department: _____

Phone: _____ **FAX:** _____

Line name: _____

Line background: _____

Any known fertility issues: _____

Identity of females: _____ **Age:** _____

Comments: _____
