

SOUTHWESTERN

THE UNIVERSITY OF TEXAS
SOUTHWESTERN MEDICAL CENTER
AT DALLAS

**TRANSGENIC TECHNOLOGY
CENTER**



**Request Form
Recovery of Cryopreserved Embryo and Transfer**

Date: _____

IDR: _____

1. **PI:** _____ **E-mail:** _____

2. **Contact:** _____ **E-mail:** _____

3. **E-mail address:** _____

4. **Department:** _____

5. **Phone:** _____ **FAX:** _____

6. **Line name:** _____

7. **Line background:** _____

8. **PI's APN:** _____

9. **PI's Animal room number:** _____

Comments: _____
