

**SOUTHWESTERN**

THE UNIVERSITY OF TEXAS  
SOUTHWESTERN MEDICAL CENTER  
AT DALLAS

**TRANSGENIC TECHNOLOGY  
CENTER**



**Request Form  
Recovery of Cryopreserved Ovaries and Transplantation**

**Date:** \_\_\_\_\_

1. **Principal Investigator:** \_\_\_\_\_
2. **Contact name:** \_\_\_\_\_
3. **E-mail address:** \_\_\_\_\_
4. **Department:** \_\_\_\_\_
5. **Phone:** \_\_\_\_\_ **FAX:** \_\_\_\_\_
6. **Identity of ovary to be transplanted:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
7. **Genetic background of parental strain:** \_\_\_\_\_
8. **Name of transgenic/KO line:** \_\_\_\_\_
9. **PI's APN:** \_\_\_\_\_
10. **PI's Animal room number:** \_\_\_\_\_
11. **Genetic background of recipient mice:** \_\_\_\_\_