

**SOUTHWESTERN**

THE UNIVERSITY OF TEXAS  
SOUTHWESTERN MEDICAL CENTER  
AT DALLAS

**TRANSGENIC TECHNOLOGY  
CENTER**



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

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

1. **Principal Investigator:** \_\_\_\_\_

2. **Contact name:** \_\_\_\_\_

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