

CRYOGENE a cryoport company	GOVERNING SOP: SAMPLE HANDLING & TRANSPORT
DOCUMENT TYPE	FORM
SOP NUMBER / FORM	201 FA
EFFECTIVE DATE/ FORM REVISION #	09-28-21/005

FORM A: SAMPLE/PRODUCT/MATERIAL TRANSPORT REQUEST

To schedule a local transport of samples to or from CryoGene via CryoGene vehicle, please email this completed form to Requests@cryogenelab.com.

NOTE: For transport of freezers/units with samples-also complete form 205FA. For shipments via commercial shipper/courier please use form 215FA.

SECTION I: TRANSPORT REQUEST INFORMATION			
CHECK ONE:		Desired Transport Date:	Desired CryoGene Arrival Time(s):
<input type="checkbox"/> Pick up samples/product for storage at CryoGene <input type="checkbox"/> Delivery of samples/product from CryoGene to client site or designated site <input type="checkbox"/> Other:			
Institution/Company	Department (required for Hospital sites)	Building/Location	Room #
Primary Contact Name	Primary Contact Email	Primary Contact Cell Phone #	Principal Investigator
Secondary Contact Name (required)		Secondary Contact Cell Phone # (required)	
SECTION II: SAMPLE/PRODUCT/MATERIAL INFORMATION			
Transport Conditions (Check one)	<input type="checkbox"/> Dry Ice <input type="checkbox"/> LN2 vapor <input type="checkbox"/> LN2 liquid <input type="checkbox"/> +2 to +8°C <input type="checkbox"/> Ambient Room Temp <input type="checkbox"/> Other (specify):	Storage Requirements (Check one)	<input type="checkbox"/> -80°C <input type="checkbox"/> -20°C <input type="checkbox"/> +2 to +8°C <input type="checkbox"/> LN2 vapor <input type="checkbox"/> LN2 liquid <input type="checkbox"/> Ambient Room Temp <input type="checkbox"/> Other (specify):
Sample/Product Container Type(s) & Quantity	<input type="checkbox"/> Vial(s) #: _____ <input type="checkbox"/> Bag(s) #: _____ <input type="checkbox"/> Cassette(s) #: _____ <input type="checkbox"/> Box(es) (measured by height) #: _____ <input type="checkbox"/> Other (specify type and quantity): _____ 2": _____ 3": _____ 4": _____ 5": _____		
Sample/Product Label ID/Cryotrax or Inventory ID (Attach separate list of sample/product label ID if needed)	Samples will be: <input type="checkbox"/> Returned to CG during this delivery <input type="checkbox"/> Returned to CG at a later date <input type="checkbox"/> N/A-samples will not be returned		
Check all that apply:	TYPE: <input type="checkbox"/> Virus <input type="checkbox"/> Bacteria <input type="checkbox"/> Blood		
	<input type="checkbox"/> Client Product (specify): _____		
	<input type="checkbox"/> Cell Line (specify): _____		
	<input type="checkbox"/> Other (specify): _____		
	<input type="checkbox"/> Human <input type="checkbox"/> Other: _____		
	STORAGE & HANDLING: <input type="checkbox"/> Infectious <input type="checkbox"/> Not Infectious		
	PURPOSE: <input type="checkbox"/> Clinical/cGMP/cGTP <input type="checkbox"/> Research <input type="checkbox"/> Other (specify): _____		
Comments:	<input type="checkbox"/> None		
Completed and Authorized by (Printed Name):	Initials or Signature	Date	

Controlled Form-Issued by CryoGene QA