CRYOGENE a cryoport company	GOVERNING SOP: **SAMPLE HANDLING & TRANSPORT**
DOCUMENT TYPE	**FORM**
SOP NUMBER / FORM	**201 FA**
EFFECTIVE DATE/ FORM REVISION #	**08-21-23/006**
FORM A: SAMPLE/PRODUCT/MATERIAL TRANSPORT REQUEST	(CRYOGENE USE ONLY) TRANSACTION ID:

To schedule a local transport of samples to or from CryoGene or site to site via CryoGene vehicle **email this completed form to** Requests@cryogenelab.com at least 24 hours prior to expected delivery date. **Call CryoGene at +1(713) 664-1600 if you have any questions.**
NOTE: For transport of freezers/storage units with samples-use Form 205FA. For shipments via commercial shipper/courier please use Form 215FA.

SECTION I: TRANSPORT REQUEST INFORMATION

SAMPLE/PRODUCT TYPE: ☐CLINICAL/GMP/GTP/GCP ☐ Research ☐Other :	Today's Date:	Desired Transport Date:	Desired CryoGene Arrival Time(s):
Service Type (Check One):			
☐ Transport TO CRYOGENE for Storage ☐ Transport FROM CRYOGENE to designated site ☐ Transfer SITE TO SITE (no storage at CryoGene):attach details			

Company	Department (required for Hospital sites)	Building/Location	Room #

Primary Contact Name	Primary Contact Email	Primary Contact Cell Phone #	Principal Investigator
			☐ N/A

Secondary Contact Name (required)		Secondary Contact Cell Phone #	

SECTION II: SAMPLE/PRODUCT/MATERIAL INFORMATION

Transport Conditions (Check one)	☐ Dry Ice ☐ LN2 vapor ☐ LN2 liquid ☐ +2 to +8°C ☐ -20°C ☐ Ambient Room Temp	Storage Requirements (Check one)	☐ -80°C ☐ -20°C ☐+2 to +8°C ☐ LN2 vapor ☐ LN2 liquid ☐ Ambient Room Temp ☐ N/A-Site to Site Transfer
Sample/ Product Container Type(s) & Quantity	☐Vial(s) #: _____ ☐ Bag(s)/ Cassette(s) #:_____ ☐Other (specify type and quantity):		☐ Box(es) (measured by height): # of 2":_____ # of 3":_____ # of 4":_____ # of 5":_____
Client Requested Inventory Mgt Level (For Storage Requests only):	☐ Box ☐ Bag/Cassette ☐ Vial *(additional fees may apply)* ☐ Other: (specify) _____ ☐ N/A		

Sample/Product Label ID(s) or Inventory ID(s) (or ☐ See Attached List/Report)

Check all that apply:	TYPE: ☐ Virus ☐ Bacteria ☐ Blood ☐ Human ☐ Tissue Type (specify): _____ Storage & Handling: ☐ Infectious ☐ Not Infectious	☐ Client Product (specify): _____ ☐ Cell Line (specify): _____ ☐Other (specify):_____

Comments: ☐ None

COMPLETED AND AUTHORIZED BY (CLIENT REP PRINTED NAME):	INITIALS OR SIGNATURE	DATE

CryoGene Use Only	*Notes or ☐ N/A*	*Received and Reviewed By Initials/Date*	

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