CRYOGENE	GOVERNING SOP: **SAMPLE HANDLING & TRANSPORT**
DOCUMENT TYPE	**FORM**
SOP NUMBER / FORM	**201 FA**
EFFECTIVE DATE/ FORM REVISION #	**07-10-26/008**
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 **Please complete and email this form to** Requests@cryogenelab.com (for the Houston Site) or SArequests@cryogenelab.com (for the San Antonio Site) at least 24 hours prior to expected delivery date**. Call CryoGene at +1(713) 664-1600 (same number for both sites) 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** ☐ **Houston or** ☐ **San Antonio for Storage** ☐ **Transport FROM CRYOGENE** ☐ **Houston or** ☐ **San Antonio 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 (Optional)	☐ N/A	**Secondary Contact Cell Phone #**	☐ N/A

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*	

Controlled Form-For CryoGene Use