Application Rec'd _____ Human Subjects Rec'd _____ Reviewed & Approved _____ Added to Req. List _____ Guidelines Sent _____ Networked : _____

APPLICATION: COOPERATIVE HUMAN TISSUE NETWORK

I. DIRECTIONS -

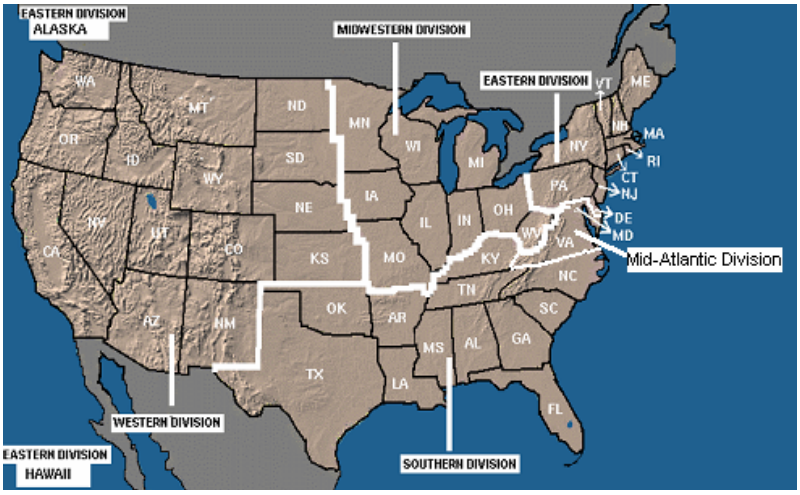
This application is intended for the use and processing of samples utilized by the laboratory and/or personnel that fall under the supervision of the PI listed in the application. Any transfer of samples or aliquots to personnel or laboratories that are not under the supervision of the indicated PI requires the following:

- An explanation of the need to transfer the materials and benefit to the investigator's research
- A copy of the enclosed CHTN agreement page signed by the collaborator
- A copy of the collaborator's IRB approval unless the collaborator is covered under the IRB approval granted for the project proposed in this application

The CHTN does not supply samples to banks solely for distribution to third party researchers; those researchers should be encouraged to apply to the CHTN directly.

The information requested in these forms is necessary in order to document correctly your request for tissue and other services and to ensure that the CHTN operates within the guidelines of the National Cancer Institute. When submitting a written request for services:

A. Please print neatly or type.
B. Please be specific about your requirements for handling tissue samples from the time the specimen is collected until it is delivered to your lab (i.e., need for sterility, transport media, refrigeration status, etc.).
C. Patient identity is confidential. Samples will be coded and delivered at a processing fee of $20/sample for researchers at academic institutions and $60/sample for researchers at non-academic institutions, plus shipping costs. Additional charges may be assessed for special preparation.
D. **Investigators must have human use approval to receive tissue from the CHTN. Either full or expedited approval can be obtained from your Institutional Review Board (Human Use Committee). A COPY OF THE HUMAN SUBJECTS APPROVAL SHOULD BE ATTACHED TO THIS FORM**. An annual human subjects review is required and must be forwarded to the CHTN in order to maintain your eligibility to receive tissue.
E. For pediatric tissue (available nationwide) please complete this application and mail directly to Children's Hospital at the address shown below.
F. For additional information call the Division for your state (see map below). Send completed forms to this division.



EASTERN DIVISION

University of Pennsylvania Med. Center
3400 Spruce Street
566 Dulles
Philadelphia, PA 19104-4283
215-662-4570
215-614-0251 (FAX)
chtneast@mail.med.upenn.edu

MID-ATLANTIC DIVISION

University of Virginia
CHTN-Department of Pathology
P.O. Box 800423
Charlottesville, VA 22906
434-924-9879
434-924-9438 (FAX)
uva-chtn@virginia.edu

MIDWESTERN DIVISION

The Ohio State University
Tissue Procurement, M376 Starling Loving Hall
320 W. 10th Avenue
Columbus, OH 43210
614-293-5493
614-293-5851 (FAX)
Johnson-60@medctr.osu.edu

PEDIATRIC DIVISION

Columbus Children's Hospital
700 Children's Drive
Room W135
Columbus, OH 43205
614-722-2714
614-722-2897 (FAX)
BrewerS@pediatrics.ohio-state.edu

SOUTHERN DIVISION

Tissue Procurement, ZRB 449
University of Alabama at Birmingham
1530 Third Ave. South
Birmingham, AL 35294-0007
205-934-6071
205-934-0816 (FAX)
sexton@path.uab.edu

WESTERN DIVISION

Vanderbilt University Medical Center
4918 TVC Boulevard
22nd & Pierce Avenue
Nashville, TN 37232-5310
615-936-2873
615-322-4741 (FAX)
kerry.wiles@vanderbilt.edu

II. INVESTIGATOR DATA

A. Principal Investigator: _____

Last Name *First Name* *Middle Initial* *Degree*

Investigator's Title: _____

Primary Mailing Address (Street/Bldg./Room#):_____

_____

Department: _____

Institution:_____

City:_____ State:_____ Zip:_____

Phone (Day):_____ (Nights/Weekends):_____

FAX Number at which you may be notified:_____e-mail_____

Contact Person:_____ Lab/Phone:_____e-mail_____

B. Shipping Address (*if different from above*): _____

Department:_____

Street/Bldg./Room#:_____

City:_____ State:_____ Zip: _____

C. Billing Information: Is a purchase order required for shipment of specimens to your institution?

Yes ____ No____ If so, please list name of contact for P.O.: _____

Name:_____Phone:_____

Currently invoices are included with the tissue shipment to the shipping address listed in section B. If you would like the original invoice to be mailed to another location (eg. your billing department), please enter that address below. A copy of the invoice will also be included with your shipment.

Billing Address (*if different from the shipping address*): _____

Department:_____

Street/Bldg./Room#: _____

City:_____ State:_____ Zip:_____

(Shipping charges will be added to your invoice unless you provide a Federal Express number.)

Federal Express Number _____

III. FUNDING INFORMATION

Tissues will be provided to investigators on a rotating basis in the following priority order:

1. Peer reviewed funded investigators (including Federal and National laboratories)
2. New investigators and academic investigators developing new research projects.
3. Other investigators

A. To help determine your priority, please include your major research grant. Institutional and other funding sources may be listed. If you are currently unfunded, please indicate below:

Funding Source	Period of Support

B. Please provide the title and a short research summary of the proposed research on the tissues you are requesting from the CHTN (*use separate page*).

IV. SERVICES REQUESTED *(Please copy this page as needed for multiple requests.)*

A. Human Tissue Specimen Criteria

1. Anatomic Site or Tissue Type:_____

_____Malignant; _____Benign; _____Normal; _____Diseased; _____Other: _____

If malignant is selected, please specify: _____ Primary and/or mets; _____ Primary only; _____ Mets only

_____ Any malignant OR _____ specify type of malignancy:_____

2. Is matched normal tissue from the same patient required? ____ Yes; ____ No; _____ If available

3. Will you accept tissue from patients previously treated with: ____ Radiation; ____ Chemotherapy

4. Must specimen be sterile? _____Yes; _____ No; _____ As clean as possible

5. Gender: _____ Male _____ Female _____ Either

6. Tissue Source:

____ Surgical: Must be frozen within _____hrs of sx OR _____time constraint not applicable

____ Autopsy: Must be collected within _____ hours after death

7. Patient Limitations (i.e., age, race, or other limiting characteristics): _____

_____

8. Amount of tissue required (minimum to maximum size or dimension): _____

9. Frequency tissue is needed:_____

10. Total number of samples needed:_____

11. Requested starting date to receive tissue: _____

B. Preparation and Preservation of Samples (*please mark only those that apply*)

____ **Fresh.** Indicate media requirements:

_____ Transport Media; _____ Saline; _____ Dry; _____ Other: _____

(if preference for transport media, e.g. RPMI, L-15, DMEM, please indicate): _____

Wrap in Gauze? _____Yes _____ No

Add supplements:

___ Antibiotics (indicate type & amount)

___ Fetal Calf Serum (indicate percentage)

___ Fungizone (indicate amount)

Shipping Requirements (wet ice, room temp. etc.)

____ **Frozen.** Indicate freezing requirements (fresh-frozen, OCT, etc.):

____ **Fixed**. Indicate fixative requirements (10% BNF, etc.):

Will you accept Saturday deliveries, if notified? _____ Yes; _____ No; _____ Sometimes, if notified

C. Sample Information Required: *(Anatomic site of tissue, provisional diagnosis, final diagnosis, quality control diagnosis and patient age, sex and race [if available] will be provided for all samples.)* **Additional patient information may be available, but you must request it in this application and justify its necessity for your research. Requests for additional information cannot be accepted after the application is received.**

(NOTE: please notify your division coordinator ASAP if your needs change).

AGREEMENT

The recipient hereby agrees: that the tissues to be provided by the Cooperative Human Tissue Network will be used only for the research purposes specified in this application; that no attempt will be made to learn the identity or other information about the subjects providing tissue; and that tissues and their directly extracted products shall not be sold (or distributed free of charge) to third parties, nor as commercial products; specifically aliquots of tissues provided by the CHTN or extracts from these tissues (e.g., protein, mRNA or DNA) shall not be distributed to third parties or marketed commercially.

We understand that while the CHTN attempts to avoid supplying tissues contaminated with highly infectious agents such as hepatitis and HIV, all tissues should be handled as if potentially infectious. Permission from patients to clinically test their tissues (e.g., for the presence of infective agents such as hepatitis) has not been obtained and such testing shall not be performed on the tissues supplied by the CHTN. If clinical information is obtained in the course of the study that is deemed by the principal investigator of the study to be important to the care of the patient who is the source of this tissue, the investigator shall request permission from his/her local IRB before contacting the CHTN regarding this information. The recipient acknowledges that he/she is aware of and follows OSHA regulations for handling human specimens and will instruct their staff to abide by those rules. The recipient further agrees to assume all responsibility for informing and training personnel in the dangers and procedures for safe handling of human tissues.

Tissues are provided as a service to the research community without warranty of merchantability or fitness for a particular purpose or any other warranty, express or implied. The CHTN accepts no responsibility for any injury (including death), damages or loss that may arise either directly or indirectly from their use.

The recipient hereby agrees to acknowledge the contributions of the Cooperative Human Tissue Network in all publications resulting from the use of these tissues. Recommended wording to the methods or acknowledgment section is as follows: *Tissue samples were provided by the Cooperative Human Tissue Network, which is funded by the National Cancer Institute. Other investigators may have received specimens from the same subjects.*

FOR STATE INSTITUTIONS: The recipient institution agrees to be responsible for any claims, costs, damages, or expenses resulting from any injury (including death), damage or loss that may arise solely from the receipt, handling, storage and use of tissues received from the CHTN to the extent permitted under the laws of this State. The undersigned warrant that they have authority to execute this agreement on behalf of the recipient institution.

FOR U.S. GOVERNMENT AGENCIES: On behalf of the United States Government, we assume all risks and responsibilities in connection with the receipt, handling, storage and use of tissues received from the Cooperative Human Tissue Network. The United States assumes liability for any claims, damages, injury or expense arising from the use of the material or any derivative, but only to the extent provided under the Federal Tort Claims Act (28 U.S.C. Chap. 171).

FOR ALL OTHER INSTITUTIONS: The recipient institution agrees to assume all risks and responsibility in connection with the receipt, handling, storage and use of tissues. It further agrees to indemnify and hold harmless the Cooperative Human Tissue Network and the United States Government from any claims, costs, damages or expenses resulting from the use of the tissues provided by the CHTN. The undersigned warrant that they have authority to execute this agreement on behalf of the recipient institution.

BY MY SIGNATURE I AGREE TO THE TERMS SET FORTH IN THE ABOVE AGREEMENT

Typed Name of Recipient	**Agency**	**Typed Name of Official Authorized to Sign for the Agency**
Signature of Recipient **Date**	**Division or Department**	**Authorized Signature** **Date**

UPON RECEIPT OF THESE SIGNED UNDERSTANDINGS AND THE INFORMATION REQUESTED ABOVE, THE COOPERATIVE HUMAN TISSUE NETWORK WILL CONSIDER THIS REQUEST AND ALL FUTURE REQUESTS FOR TISSUE. Specific questions about your application should be directed to your regional coordinator. Other questions may be directed to the NCI Program Director, Ms. Marianna Bledsoe at 301-496-7147.