



Tissue Request Form

T (877)738-6555 | F (877)738-2111 | www.unitedtissue.org
 Phoenix, AZ | St. Petersburg, FL | Norman, OK

Requestor

Today's Date:		Institution Address:	
Institution:			
Requestor Name:			
Phone #:		Institution Email*:	

Tissue Details/Use

Date of Use:		Camera Usage:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Ship to Arrive:	<input type="checkbox"/> Embalmed	<input type="checkbox"/> Frozen	<input type="checkbox"/> Injected	<input type="checkbox"/> Partially Thawed	<input type="checkbox"/> Thawed
Requested Tissue Type and Quantity:					
Requested Tissue Criteria/Special Instructions:					
Scans Required:	<input type="checkbox"/> Yes <input type="checkbox"/> No (<input type="checkbox"/> Pre <input type="checkbox"/> Post <input type="checkbox"/> CT <input type="checkbox"/> MRI <input type="checkbox"/> X-Ray <input type="checkbox"/> Dexa)				
Donor/Scans Pre-Approval:	<input type="checkbox"/> Yes <input type="checkbox"/> No				
	If Yes, extra fees apply				
Equipment Rental:	<input type="checkbox"/> Yes <input type="checkbox"/> No				
List if Yes:					
Detailed Description of Use of Tissue (i.e. describe procedures, course, etc.): (attach additional pages as needed) *Please include any promotional material that is being used for this course, if applicable.					

Description of Venue and Security Measures Used for Maintaining the Custody of Human Tissue, Before, During, and After use:
 (attach additional pages as needed) Must be lockable with restricted private access. Must have appropriate signage.

Shipping Information

Shipping Address: Same as above	Arrival Date/Time:	
	Ship to Attention:	
	Is this an international Order:	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Phone #:	

Special Shipping Instructions:	
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E-Mail*:	
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*This E-Mail is where Donor Medical/Social Histories and Serology Results will be sent. Include everyone who will require a copy.

Billing Information

Billing Address: Same as Institution Same as Shipping	Bill to Attention:	
	Phone #:	
	E-Mail Address:	
P.O. Required	<input type="checkbox"/> Yes <input type="checkbox"/> No	Does this order need pre-payment <input type="checkbox"/> Yes <input type="checkbox"/> No

Tissue Disposition

Will the tissue be returned to UTN:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pickup Date/Time:	
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If you will not be returning the tissue to UTN, please complete the following information:

Name & Address of Disposition Facility:	Contact Name:	
	Phone #:	
	Disposition Method:	<input type="checkbox"/> Cremation <input type="checkbox"/> Incineration
	Disposition Date:	

Authorization

Applicant

By signing below, you agree, on behalf of the requesting institution, that the information listed above is correct and accurate. You also agree that the institution will adhere to the details outlined in the executed Anatomical Material Transfer Agreement.

Authorized Signature:		Date:	
Printed Name:		Title:	

United Tissue Network

Authorized Signature:		Date:	
Printed Name:		Order #:	