



Gene Transfer Sample Repository Submission Form

PART 1: Instructions

To submit samples to the NGVL for the Gene Transfer Sample Repository, please complete all appropriate fields on the form below (**red text denotes required fields**). The form must be submitted by printing a hard copy using the print button at the bottom of this form. The printed copy must be signed as indicated and must accompany the shipped material. Note: subject information will be encoded and "grayed out" in order to protect confidentiality. Archiving and clonality screening (if required) are free to academic investigators. The cost of sample shipment is the responsibility of the submitting institution or investigator.

The person completing the form must sign and date a hard copy of the form and send it with the sample by overnight delivery service to:

<p>NGVL Gene Transfer Sample Repository Department of Medical and Molecular Genetics Indiana University School of Medicine 975 West Walnut Street, IB-555 Indianapolis, IN 46202</p> <p>Phone: (317) 278-1633</p>	
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PART 2: Services Requested (indicate all that apply)

Archiving of DNA

Clonality Screening (for integrating vectors only)

***NOTE:** If clonality screening is requested, the vector sequence must be on file with the NGVL. To submit sequence data please contact the NGVL Gene Transfer Sample Repository at the number above for instructions.*

PART 3: Principle Investigator or Responsible Individual Information

The PI is the only individual to receive reports and the only one to whom archived material will be released. The responsible institution can appoint another individual in place of the PI but must inform the NGVL in writing of the change prior to the next sample submission or material/report request.

First		Last	
Department		Institution	
Address		Bldg/Room #/Mail Stop	
City		State	
Zip		Phone	
Fax		Alt. Phone	

PART 4: Submitting Institution and Contact Information

Check here if submitting institution is different from institution where gene transfer therapy was initially performed.

Department		Institution	
Address		Bldg/Room #/Mail Stop	
City		State	
Zip		Phone	
Fax		Alt. Phone	
Contact Person*		Contact Person Phone*	
Was sample collected at a GCRC?			
<i>*If different from PI</i>			

PART 5: Subject Information

First		Middle	
Last		DOB	
Your Subject ID			
Date of initial gene transfer treatment			

PART 6: Gene Transfer Information

Vector Type		If Other, specify	
Vector Name		IND#	
Institutional Protocol Number			

PART 7: Sample Information

Sample Type		If Other, specify	
Sample Collected/Supplied In:			
If Other, specify		Sample Size (in mL)	
Date Shipped		Date Collected	
Additional Comments			

PART 8: Check List for Shipping

All required fields completed...	
Information checked for accuracy...	
Sample is NOT shipping on a Friday, Saturday or Sunday...	
Subject Sample packaged appropriately...	
Name of person responsible for shipping the sample...	
Name of person who filled out this form and signing below...	
For Hard Copy Version Form Completed By: (Signature/Date)	