

## APPLICATION: SCI at SIU School of Medicine Tissue Bank

**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.

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 SCI Tissue Bank operates within the guidelines of its Protocol and applicable state, federal, and institutional guidelines. When submitting a written request for services:

- A. Please print neatly or type.
- B. Please be specific about your requirements for handling tissue (i.e., refrigeration status).
- C. Patient identity is confidential. Samples will be coded and delivered at a processing fee of \$20/sample plus any applicable shipping costs. Additional charges may be assessed for special preparation.
- D. **HUMAN SUBJECTS APPROVAL SHOULD ALSO BE ATTACHED TO THIS FORM WHEN APPLICABLE.**
- E. A new Application and Use Agreement is required for each new request.

**II. INVESTIGATOR DATA**

A.	Principal Investigator: _____ <table style="width: 100%; border: none;"> <tr> <td style="width: 30%; border: none;">Last Name</td> <td style="width: 30%; border: none;">First Name</td> <td style="width: 20%; border: none;">Middle Initial</td> <td style="width: 20%; border: none;">Degree</td> </tr> </table> Investigator's Title: _____ Investigator's Date of CITI Training ____/____/____ (MM/ DD/ YYYY)  Primary Mailing Address Street Address: _____ Room/Bldg.: _____ Department: _____  Institution: <input type="checkbox"/> SIU School of Medicine <input type="checkbox"/> Southern Illinois University City: _____ State: _____ Zip Code: _____ Attention: _____  Investigator Phone (Day): _____ Ext. _____ (Nights/Weekends): _____ Ext. _____ FAX Number at which you may be notified: _____ e-mail: _____	Last Name	First Name	Middle Initial	Degree
Last Name	First Name	Middle Initial	Degree		
Laboratory Contact Person: _____ Alternate Contact: _____ Lab/Phone: _____ Ext. _____ e-mail: _____					
B.	Shipping Address (if different from above): Street Address: _____ Room/Bldg.: _____ Department: _____ Institution: _____ City: _____ State: _____ Zip Code: _____ Attention: _____				

C. Billing Information: Account Number/ Budget Purpose Number to be billed: \_\_\_\_\_

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 mailed to you. If you would like them mailed to another location (e.g. your billing department), please enter that address below.**

Billing Address (if different from the shipping address):  
 Institution: \_\_\_\_\_  
 Department: \_\_\_\_\_  
 Street Address: \_\_\_\_\_  
 Room/Bldg.: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Attention: \_\_\_\_\_ Courier Account Number: \_\_\_\_\_

**PLEASE provide a courier account number. If a courier account number is not provided, shipping charges will be added to your invoice.**

**III. FUNDING INFORMATION FOR THE PROJECT SPECIMENS ARE BEING PURCHASED FOR**

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 For This Project

Period of Support

Funding Agency	Grant Number	Start Date	End Date	Comment

B. Please provide the title and a short research summary of the proposed research on the tissues you are requesting from the SCI Tissue Bank (*use separate page*). If additional specific specimen parameters are needed for a specimen that are not currently provided or addressed in this application please indicate so in section D below. The Tissue Bank may or may not be able to meet your request.

**IV. SERVICES REQUESTED**

**A. Human Tissue Specimen Criteria**

**NOTE: A NEW APPLICATION MUST BE FILLED OUT FOR EACH DIFFERENT TYPE OF TISSUE OR ANATOMIC SITE (i.e. breast, prostate, colon)**

Anatomic Site and Tissue Type: \_\_\_\_\_

Malignant  Benign  Normal  Diseased:  Other:  
 If malignant is selected:  Primary and/or mets  Primary only

Anatomic Comment: \_\_\_\_\_

Is matched peri-normal tissue from the same patient required?  Yes, any tissue  If possible, any tissue  
 No  Not Applicable

Please Note that specimens must be purchased in matched sets of peri-normal and malignant tissue unless set is not available.

Match Comment: \_\_\_\_\_

Is serum from the same patient required?  Yes  No

Is whole blood from the same patient required  Yes  No

Gender \_\_\_\_\_ Race \_\_\_\_\_ What are your age limitations? \_\_\_\_\_

Will you accept tissue from: Surgery \_\_\_\_\_ Time Constraints \_\_\_\_\_ Post  
 Transplant \_\_\_\_\_ Time Constraints \_\_\_\_\_ Post  
 Autopsy \_\_\_\_\_ Time Constraints \_\_\_\_\_ Post

**B. Preparation and Preservation of Specimens**

**Fresh Specimen(s) Requested Note: Media or solution must be provided by the Recipient Investigator**

Must Specimen be Sterile? \_\_\_\_\_ Wrap in Gauze? \_\_\_\_\_

Fresh Prep Comments (e.g. specifics regarding media and shipping requirements for fresh specimen(s)): \_\_\_\_\_

**Snap-Frozen Specimen(s) Requested**

Frozen Preparation \_\_\_\_\_

Frozen Preparation Comments \_\_\_\_\_

**Fixed Specimen(s) Requested**

Fixed Preparation \_\_\_\_\_

Fixed Preparation Comments \_\_\_\_\_

**C. Additional Specifications**

Amount of tissue required (minimum and maximum weight in grams): \_\_\_\_\_

Total number of specimens needed: \_\_\_\_\_

True Normal \_\_\_\_\_

Malignant Disease w/ match peri-normal \_\_\_\_\_

serum \_\_\_\_\_

Whole blood \_\_\_\_\_

other \_\_\_\_\_

Requested starting date to receive tissue: \_\_\_\_\_

**D. Additional Specimen parameters**

Are identifiers being requested? \_\_\_\_\_

Prior Treatment options required? \_\_\_\_\_

Pathological data required? \_\_\_\_\_

Other? \_\_\_\_\_

**V. NOTICE**

Although the TBF attempts to avoid supplying tissues contaminated with highly infectious agents, all tissues should be handled as if potentially infectious. The TBF will not be liable for any injury (including death), damage or loss that may arise either directly or indirectly from their use.

The investigator assumes all risks and responsibility in connections with receipt, handling, storage, use, or disposal of tissues. The investigator receiving these tissues also assumes full responsibility for informing and training all personnel in the dangers and procedures for safe handling of these and other human tissues. The TBF will not be liable to the investigator or any personnel for any loss, claim, or demand made by the investigator or any personnel, or made against the investigator or any personnel by any other party from the receipt, handling, storage, use, or disposal of tissues by investigator.

The investigator agrees to indemnify and hold harmless the SIU Cancer Institute and SIU from any and all claims, costs, damages or expenses resulting from any injury (including death), damage or loss that may arise from the receipt, handling, storage, use, or disposal of tissues provided by the TBF.

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

\_\_\_\_\_  
Name of Recipient (Please Print)

\_\_\_\_\_  
Signature of Recipient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Division or Department

**REQUEST APPROVED BY COMMITTEE: \_\_\_\_\_ YES \_\_\_\_\_ NO**  
\_\_\_\_\_  
**TISSUE BANK DIRECTOR OR DESIGNEE SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

**Additional Information Request-Possible**

<b>Yes/ No</b>	<b>Variable- IRB Review Required</b>	<b>Yes/ No</b>	<b>Variable-IRB Review May be Required</b>
	<b>Names</b>		<b>Family history general (yes or no)</b>
	<b>Initials</b>		<b>Family History specific (which family member)</b>
	<b>Address, including full or partial zipcode</b>		<b>Prior Treatment general (yes/ no, surgery, chemo, etc.)</b>
	<b>Telephone or fax numbers</b>		<b>Prior Treatment specific (which chemo. drug, type of surgery, etc.)</b>
	<b>Contact information</b>		<b>Metastasis of tumor</b>
	<b>Email addresses</b>		<b>Place of treatment</b>
	<b>Unique Identifying Numbers (MRN, SSN, VIN, etc.)</b>		<b>Physicians associated with patient or treatment</b>
	<b>Dates Related to an individual (including birth date)</b>		<b>Anthropometry measures (height, weight, BMI, etc.)</b>
	<b>Medical Device identifiers</b>		<b>Rare disease or treatment diagnosis</b>
	<b>Web or internet addresses</b>		<b>Sensitive data (i.e. drug use)</b>
	<b>Biometric data (i.e fingerprints or voice prints)</b>		<b>Socioneconomic data (insurance, work place, income, education)</b>
	<b>Facial or other photographs</b>		<b>Place of birth</b>
	<b>Audiotapes</b>		<b>Gender</b>
	<b>Names of relatives</b>		<b>Ethnicity</b>

**Please note that information may be requested but that information provided will be dependent on whether an IRB approval is needed for release of information and what information is available. This table is intended only to list possible variables and to clarify what information is requested. If the information is required please note that in the Yes/ NO box). If the information requested is not listed in the table, please write in that which is requested on the blank lines. General pathology information is provided with the specimen without additional requests.**

# SCI TISSUE BANK USE AGREEMENT

This agreement governs use of the research materials supplied to the recipient investigator (hereafter "RECIPIENT") by the Simmons Cancer Institute (SCI) Tissue Bank at Southern Illinois University's School of Medicine (hereafter "TISSUE BANK"). These materials were collected under Protocol #08-112 as approved by the institutional review board (Springfield Committee for Research Involving Human Subjects [SCRIHS]).

Only the following information will be supplied (as available) for the stored biological specimens:

gender, age (up to age 90 or stated as > 90), race, histological and pathological information of the specimen.

If RECIPIENT requires additional information pertaining to the specimens or the specimen donor, RECIPIENT must submit and obtain a separate use protocol with the Springfield Committee for Research Involving Human Subjects. Absent any required approvals, RECIPIENT shall not re-identify the Material or contact a respective donor, nor attempt the same.

The RECIPIENT agrees that the research material and information ("Material") to be provided by the TISSUE BANK will be used only for the research purposes specified in the corresponding application and as otherwise required by law and that tissues and their products shall not be sold (or distributed free of charge) to third parties, nor used to produce commercial products (including the production of cells or cell products for sale). Any additional use of the Material requires prior approval by the Tissue Bank Committee and, in certain circumstances, by SCRIHS.

RECIPIENT acknowledges that the conditions for use of the Material are governed by the TISSUE BANK ADVISORY COMMITTEE and SCRIHS in accordance with Department of Health and Human Service regulations at 45 CFR 46. RECIPIENT agrees to comply fully with all such conditions and to report promptly to the TISSUE BANK any (i) proposed changes in the research project, (ii) any unanticipated problems involving risk to subjects or others, or (iii) disclosure of Material which is not consistent with this Agreement. RECIPIENT remains subject to applicable State or local laws or regulations and institutional policies which provide additional protections for human subjects.

RECIPIENT shall use appropriate safeguards to prevent uses or disclosures of Material which are not consistent with this Agreement. RECIPIENT shall ensure that any agents to whom it provides the Material agree to abide by the same restrictions and conditions of this Agreement, and shall further ensure that sharing of said Material is permissible under this Agreement and applicable law.

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Tissue Bank Director Signature	Printed Name	Date
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Tissue Bank Technician Signature	Printed Name	Date
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Data Manager Signature	Printed Name	Date
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<b>Recipient Investigator Signature</b>	Printed Name	Date
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