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| --- | --- | --- | --- | --- | --- |
| Date of Submission: |  | | | | |
| **REQUESTER’S NAME AND CONTACT INFORMATION** | | | | | |
| Name: |  | | | | |
| Institution/Affiliation: |  | | | | |
| Institution Type: | 🞏 Academic 🞏 Industry 🞏 Other, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| Contact Information: | Email: |  | | Telephone: |  |
| **PROJECT DETAILS** | | | | | |
| Project Title: |  | | | | |
| Short Title:  (for ease of reference) |  | | | | |
| PI Name: |  | | | | |
| Background:  (2-3 sentences) |  | | | | |
| Scientific Aims:  (2-3 sentences) |  | | | | |
| Methods/Approach:  (2-3 sentences) |  | | | | |
| Significance:  (2-3 sentences) |  | | | | |
| Anticipated Date of Project Completion: |  | | | | |
| Funding Source(s):  (select all that apply) | □ Federal (if U.S.) □ Foundation □ Industry  □ Other, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| Funding Agency, Grant#, and PI of Grant:  (list all) | | |  | | |

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| **BIOLOGICAL SAMPLES REQUESTED** |

1. **What type of Samples would you like?**

Example: If you need serum samples and the experiment requires 80-100 µl per sample, check the box for “Serum” below and enter “80-100 µl” under quantity.

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| --- | --- | --- |
| **Sample Type** | **Quantity**  (e.g. volume, concentration, # of cells, ...) | **Other Specifications for Sample Condition**  (e.g. max # of freeze-thaw cycles tolerable, fasting samples only, ...) |
| 🞏 DNA |  |  |
| 🞏 Plasma |  |  |
| 🞏 Buffy Coat |  |  |
| 🞏 Serum |  |  |
| 🞏 RNA |  |  |
| 🞏 PBMC |  |  |
| 🞏 Transformed  Lymphoblasts |  |  |
| 🞏 CSF |  |  |
| 🞏 Urine |  |  |

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| **BIOLOGICAL SAMPLES REQUESTED (cont.)** |

1. **From which type of PARTICIPANTS would you like samples?**

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| --- | --- | --- |
| **Clinical**  **Diagnosis** | **Number of Participants Requested** | **Inclusion/Exclusion Criteria**  (e.g. SOD1 A4V only, female and age at collection < 50 years,  baseline visit > 2 years since diagnosis, no diabetes or peripheral neuropathy, no frontotemporal spectrum disorder, not on a particular therapeutic agent [e.g. riluzole] at time of sample collection, ...) |
| 🞏 ALS |  |  |
| 🞏 PMA |  |  |
| 🞏 HSP |  |  |
| 🞏 PLS |  |  |
| 🞏 Controls\* |  |  |

\*Note: Control samples are not yet available in CReATe

1. **Please specify any MATCHING CRITERIA (e.g. age, sex, ...) between diagnosis groups:**

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1. **Would you like samples from A SINGLE TIME POINT or MULTIPLE TIME POINTS per person?**

🌕 Single time point (i.e. cross-sectional samples)

🌕 Multiple time points (i.e. longitudinal samples), specify:

* + 1. # of time points per person: \_\_\_\_\_\_
    2. Other specifications (e.g. only want longitudinal samples at least 6 months apart):

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1. **Additional specifications not covered above:**

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| **CLINICAL DATA REQUESTED** | |
| Specify Required Data/Variables: |  |

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| **SHIPMENT INFORMATION & LABORATORY CONTACT** | |
| Name: |  |
| Telephone: |  |
| Email: |  |
| Shipping Address: |  |
| FedEx (or Other) Account Number: |  |
| Special Instructions, If Any: |  |

**FOR INTERNAL USE ONLY**

|  |  |
| --- | --- |
| Request ID: |  |
| Date request received: |  |
| Signed documents received: | 🞏 MTA, date: \_\_\_\_\_\_\_\_\_\_ 🞏 Investigator Assurance, date: \_\_\_\_\_\_\_\_\_\_ |
| Requires review by CReATe Resource Access Committee: | 🌕 No 🌕 Yes, date of review: \_\_\_\_\_\_\_\_\_\_ |
| Decision: | 🌕 Approved  🌕 Denied, reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Date of approval/denial notification to requester: |  |
| Samples shipped date: |  |
| Notes or comments: |  |