CENTRE FOR Genome Engineering

Transgenic Services

Request For Sperm Cryopreservation

Telephone: (403) 210-9311
Email: transgen@ucalgary.ca
Fax: (403) 210-9312

FACULTY OF MEDICINE | UNIVERSITY OF CALGARY

Investigator: _____ Date Submitted: _____

Contact: _____ E-mail: _____

Phone: _____ Protocol#: _____

Barrier Facility: MSBU /MDBU Animal Room #: _____

Strain to be: _____ Genetic Background of: _____
Preserved Strain: (e.g.C57BL6J or N)

Homozygous or
Heterozygous males: _____ Proven Breeders? Yes: _____ No: _____

Description of Phenotype of Strain: _____

_____

_____

Date of Birth of Donor Males #1: _____

#2: _____

Date of Last Mating #1: _____

#2: _____

PI/Authorized Account User Signature*_____

**This signature indicates that there are sufficient funds in the project code to cover the expenses incurred*
**A separate invoice will be sent after services have been rendered, no need to include accounting string now*

Transgenic Facility Use Only

Date(s) of freezing: _____

Notes: _____

#Straws Frozen: _____ _____

_____

#Straws thawed for IVF: _____ _____

#2 cell embryos post IVF: _____ Sperm Concentration: _____

Location of stored straws: _____