CENTRE FOR Genome Engineering

Request For Sperm Cryopreservation

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

FACULTY OF MEDICINE | UNIVERSITY OF CALGARY

Investigator: _____ Date Submitted: _____

Contact: _____ E-mail: _____

Phone: _____ Protocol & Allocation#: _____

Original strain location: CCCMG/MDBU Animal Room# rack#: _____

Strain to be Preserved: _____ Background Strain: _____ (e.g.C57BL6J/N)

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

Description of Phenotype of Strain: _____

_____

_____

Date of Birth of Donor Males #1: _____ MOSAIC ID# _____

#2: _____ MOSAIC ID# _____

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*
**Note the account indicated will be charged after services have been rendered*

Transgenic Facility Use Only

Date(s) of freezing: _____

#Straws Frozen: _____

Straw # thawed for IVF: _____

#2 cell embryos post IVF: _____

Location of stored straws: _____

Notes: _____

[Sperm fresh]: _____

[Sperm thaw]: _____