Request for Ocular Tissue for Research and Training

Name ____________________________________________
Phone________________ Fax ___________________ Email ________________________________

☐ Current resident at the University of Colorado Health Sciences Center

☐ Current faculty or staff at the University of Colorado Health Sciences Center

Use of tissue_______________________________________________

Is this a funded research project? □ YES □ NO

Date tissue is needed _____________________

If outside of the Denver metropolitan area, include shipping instructions (shipping fees apply)

Tissue Requested

<table>
<thead>
<tr>
<th>TISSUE</th>
<th>QUANTITY</th>
<th>LENS PREFERENCE</th>
<th>SPECIAL REQUIREMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fresh Whole Globe</td>
<td>□ aphakic □ pseudophakic □ phakic □ no preference</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cornea</td>
<td>□ aphakic □ pseudophakic □ phakic □ no preference</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>□ aphakic □ pseudophakic □ phakic □ no preference</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

☐ Check here if donor serology is required. List necessary tests (provided with additional fees, fee schedule available)

___________________________________________
Signature
___________________________________________
Date

Faculty Signature (required for requests from ophthalmology residents)
___________________________________________
___________________________________________

Email completed form to distribution@corneas.org or fax to 720-848-3947