BSL3 Room Study Request Form

Contact Information

Principal Investigator: _____ Phone: _____

Laboratory Point of Contact: _____ Phone: _____

Project Information:

Agent: _____

Approved IBC Protocol Number: _____ Approved IACUC Protocol Number:_____

Kick-off meeting completed for lab

- ◯ Yes Date of completion: _____
- ◯ No Date scheduled: _____

Kick-off meeting completed for VetMed

- ◯ Yes Date of completion: _____
- ◯ No Date scheduled: _____
- ◯ N/A

Requested Start Date: _____ Projected Length of Study_____

Room(s) requested: _____

Laboratory Staff Support

Note: Any person who may work on the study must be listed. Using "HCRPC" or "VCIPS" will not be accepted

Name (first and last)	Role(s) in Study	Weekend Support Role (Y/N)

Clinical Pathology

Providing Support for Study: ◯ Yes ◯ No

If yes, has lab confirmed process for after hour/weekend necropsy: ◯ Yes ◯ No ◯ N/A

Necropsy/Pathology

Lab confirmed process for afterhours work (e.g., weekend necropsies) ◯ Yes ◯ No ◯ N/A

Equipment/Supplies:

If incubators are to be used, indicate whether CO_2 will be needed

Procedures and Assays

Procedure	SOP been formatted to QA standards (Y/N)