Tissue Request Form
For Research Use

Contact Information

Organization Name: _____

Principle Researcher's name: _____

Contact Person: _____ Email: _____

Phone: _____ Fax: _____

Shipping Information

Facility Name: _____

Delivery Address: _____

_____

Special Instructions: _____

_____

* Additional Charges May Apply

Contact Information

Billing Contact: _____

Billing Address: _____

Phone: _____ Fax: _____

P.O #: _____

Vision Share Distribution Center
888-657-SIGHT (888.657.4448)
dc@visionshare.org
Available 24 hours a day, 7 days a week

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Research Data

Summarize project(s) that will utilize tissue or attaché an existing description:_____

_____

_____

_____

_____

Tissue Information

Tissue Type: ☐ Cornea ☐ Whole Globes ☐ Posterior Poles

Amount Desired:_____

Will these be distributed to anyone else: ☐ Yes ☐ No

Donor Age Criteria:_____

Prior ocular surgery acceptable? ☐ Yes ☐ No

Conditions not allowed (e.g. diabetes, sepsis, chemo):_____

_____

Serology Needed: ☐ Yes ☐ No (additional charge applies)

Does sterile technique need to be maintained: ☐ Yes ☐ No

Preservation Method:_____

Other Criteria:_____

The above statements are true; the tissue requested will be used only for the purposes stated. It is understood that you are accepting full responsibility for this research tissue and you will use Universal Precautions when handling the tissue

Print Name:_____ Date/Time:_____

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