



# Gene Targeting & Transgenic Facility

## Embryo Cryopreservation Request Form

Date received \_\_\_\_\_

PI Name \_\_\_\_\_ Department \_\_\_\_\_

Room Number \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Contact Person \_\_\_\_\_ Mail Code \_\_\_\_\_

Phone \_\_\_\_\_ Email \_\_\_\_\_

Person/Dept. to whom billing should be directed: \_\_\_\_\_ FRS code \_\_\_\_\_

Project title \_\_\_\_\_

NIH-Agency award # \_\_\_\_\_

ACC# and protocol title \_\_\_\_\_

Mouse line to be cryopreserved \_\_\_\_\_

Strain of mice to be cryopreserved: CD1 C57B/16 FVB

129 Other \_\_\_\_\_

Genotype: homozygote Heterozygote

Number of stud males \_\_\_\_\_ Age \_\_\_\_\_

If the mice are maintained as homozygote: number of donor females \_\_\_\_\_ Age \_\_\_\_\_

Present location of animals \_\_\_\_\_

Please provide us with the most recent health report.

Outline reasons for the procedure:

What is known about the reproductive performance of these animals? (i.e. age of female for first litter, number of pups/litter, how many litters to expect, are the females good mothers, are animals of either sex aggressive, etc)

Signature of Principal Investigator \_\_\_\_\_ Date \_\_\_\_\_

Please complete this form and return it to:

Dr. Caiying Guo  
Gene Targeting and Transgenic Facility  
University of Connecticut Health Center  
Room EB010            MC 3001  
263 Farmington Avenue, Farmington, CT 06030  
Phone: 860-679-4032  
Fax: 860-679-1846  
Email: [guo@neuron.uhc.edu](mailto:guo@neuron.uhc.edu)  
Web: <http://gttf.uhc.edu/>

Check list:

1. Completed request form.
2. A copy of your animal care protocol.
3. The most recent health report.