TRANSGENIC & CHIMERIC MOUSE FACILITY

Location: 38 Clinical Research Building
Tel: 215/573-3023; 215/746-6392
Fax: 215/573-5892
Web: *http://www.med.upenn.edu/tcmf*

Mailing Address:
502 Clinical Research Building
415 Curie Boulevard
Philadelphia, PA 19104-6145

Transgenic Mouse Request Form

- *Please attach a gel photo and a linear map of the construct to this form. The map should indicate locations of: Promoter/ enhancer, splice site, poly A site, and CAP site.*
- *Please submit copies of the approval letters from the IBC and IACUC committees*

Investigator:____________________ Department: ____________________

Address: ____________________ Email: ____________________

Telephone: ____________________ Fax: ____________________

Contact Person: ____________________ Email: ____________________

Phone: ____________________ Fax: ____________________

IACUC Protocol Title: ____

IACUC Number: ____________________ Approval Date: ____________________

IBC Number: ____________________ Approval Date: ____________________

Bill To:____________________ Telephone:____________________

Address:____________________ Department:____________________

Purchase Order #: ______________ Email: ______________ Fax:______________

Construct: __________ Concentration: __________ Amount:__________ Promoter/Enhancer: __________

Has this regulatory element been proven to produce tissue-specific expression in transgenic mice? ☐ Yes ☐ No If "yes", specify tissue: ____________

Has this construct been expressed in a eukaryotic system? ☐ Yes ☐ No

For cDNA's:
Does construct contain any introns? ☐ Yes ☐ No If "yes", specify location: ____________

How was DNA purified? ____________________ DNA tube label ____________________

Primers Name: ______________Concentration: ______________ Fragment Size: ______________

Where will the animals be housed? Facility: ____________________ Room number:__________

Please provide a brief description of the project and its aims below (Use attached sheet only if necessary):

____

____

Investigator's Signature: ____________________ Date: ____________

TCMF STAFF ONLY
Received by: ____________________ Date: ____________

TRANSGENIC & CHIMERIC MOUSE FACILITY

Location: 38 Clinical Research Building
Tel: 215/573-3023; 215/746-6392
Fax: 215/573-5892
Web: *http://www.med.upenn.edu/tcmf*

Mailing Address:
502 Clinical Research Building
415 Curie Boulevard
Philadelphia, PA 19104-6145

Transgene Screening Results

- *Failure to report results within 45 days of receiving the tail samples will result in the forfeiture of your right to a free re-injection in the event that only 0-2 founder mice can be detected*
- *Once results become available, please return this form to:* *Dr. Jean Richa*
  Department of Genetics
  502 Clinical Research Building / 6145

Investigator:____ Department: ____________________________________

Address: ____ Email: ____

Telephone: ____ Fax: ____

Contact Person: ____ Email: ____

Telephone: ____ Fax: ____

Number of mice/tails reveived from TCMF:________________________ Date: _______________

Date of biopsy analysis: ___________________________________ Number of Transgenics: _____________

ID Number of Transgenics: ________________________________

Attached Documents (e.g., gel photo, autoradiogram, etc.):

____

____

____

____

Project Scientist: ____

Signature: ____ Date: ________________

TRANSGENIC & CHIMERIC MOUSE FACILITY

Location: 38 Clinical Research Building
Tel: 215/573-3023; 215/746-6392
Fax: 215/573-5892
Web: *http://www.med.upenn.edu/tcmf*

Mailing Address:
502 Clinical Research Building
415 Curie Boulevard
Philadelphia, PA 19104-6145

Chimeric Mouse Request Form

- *Please attach a schematic diagram of the recombination strategy and a photo of the recombination detection analysis*
- *Please submit copies of the approval letters from the IBC and IACUC committees*

Investigator: ____________________ Department: ____________________

Address: ____________________ Email: ____________________

Telephone: ____________________ Fax: ____________________

Contact Person: ____________________ Email: ____________________

Telephone: ____________________ Fax: ____________________

IACUC Protocol Title: ____________________

IACUC Number: ____________________ Approval Date: ____________________

IBC Number: ____________________ Approval Date: ____________________

Bill To: ____________________ Telephone: ____________________

Address: ____________________ Department: ____________________

Purchase Order #: ____________________ Email: ____________________ Fax: ____________________

ES cell line: ____________________ Passage Number; ____________________

Has this cell line been tested for chimerism prior to recombination? ☐ Yes ☐ No

If "No", please explain: ____________________

____

Brief description of the project and it's aims: (Use attached sheet if necessary)

____

____

____

____

____

____

Investigator's Signature: ____________________ Date: ____________________

TCMF STAFF ONLY
Received by: ____________________ Date: ____________________

TRANSGENIC & CHIMERIC MOUSE FACILITY

Location: 38 Clinical Research Building
Tel: 215/573-3023; 215/746-6392
Fax: 215/573-5892
Web: *http://www.med.upenn.edu/tcmf*

Mailing Address:
502 Clinical Research Building
415 Curie Boulevard
Philadelphia, PA 19104-6145

Genome-edited Mouse Request Form

- *Please attach any documentation on the gRNA's and the mutation site(s).*
- *Please submit copies of the approval letters from the IBC, and IACUC committees*

Investigator: ____________________ Department: ____________________

Address: ____________________ Email: ____________________

Telephone: ____________________ Fax: ____________________

Contact Person: ____________________ Email: ____________________

Phone: ____________________ Fax: ____________________

IACUC Protocol Title: ____________________

IACUC Protocol Number: ____________________ IACUC Approval Date: ____________________

IBC Number: ____________________ IBC Approval Date: ____________________

BA's Name: ____________________ Telephone: ____________________

Address: ____________________ Department: ____________________

Purchase Order #: __________ Email: ____________________ Fax: __________

RNA Project: ____________________

Concentration of Cas9 RNA: ____________________ Cas9 Protein: ____________________

Number of gRNA: ____________________ Concentration: ____________________

Number of Oligo DNA: ____________________ Concentration: ____________________

Number of dsDNA Template: ____________________ Concentration: ____________________

Deletion Size: ____________________ Insertion Size: ____________________

Mouse Strain: ____________________ Number of Insertions: ____________________

How was RNA Purified? [ ]

RNA Tube label: ____________________

Primers Name: ____________________

Primer Concentration (μM) __________ Fragment size(*bp*) __________

Please provide a brief description of the project and its aims below (Use attached sheet only if necessary):

____

____

____

____

Investigator's Signature: ____________________ Date: __________

TCMF STAFF ONLY
Received By: Date:

TRANSGENIC & CHIMERIC MOUSE FACILITY

Location: 38 Clinical Research Building
Tel: 215/573-3023; 215/746-6392
Fax: 215/573-5892
Web: *http://www.med.upenn.edu/tcmf*

Mailing Address:
502 Clinical Research Building
415 Curie Boulevard
Philadelphia, PA 19104-6145

Embryo Cryopreservation Request Form

Investigator:____ Department: _____________________________________

Address: ____ Email: ____

Telephone: ____ Fax: ____

Contact Person: ____ Email: ____

Telephone: ____ Fax: ____

IACUC Protocol Title: ____

IACUC Number: ____ Approval Date: ___________________________________

IBC Number: ____ Approval Date: ___________________________________

Bill To:____ Telephone:_______________________________________

Address:____ Department:_____________________________________

Purchase Order #:_____________________________ Email: __________________________ Fax: _______________________

Mouse Line(s) Identification Number(s): ____

Where will the animals be housed? Facility: __________________________________ Room Number: _____________________

Would the proposed number of embryos to be frozen be sufficient for your lines? ☐ Yes ☐ No

If "No", please explain: ____

____

____

____

____

____

____

Investigator's Signature: ____ Date: _________________

TCMF STAFF ONLY
Received by: ____ Date: _________________

TRANSGENIC & CHIMERIC MOUSE FACILITY

Location: 38 Clinical Research Building
Tel: 215/573-3023; 215/746-6392
Fax: 215/573-5892
Web: *http://www.med.upenn.edu/tcmf*

Mailing Address:
502 Clinical Research Building
415 Curie Boulevard
Philadelphia, PA 19104-6145

Mouse Line Rederivation Request Form

Investigator:_______________________________________ Department: _______________________________

Address: _______________________________________ Email: _______________________________

Telephone: _______________________________________ Fax: _______________________________

Contact Person: ___________________________________ Email: _______________________________

Telephone: _______________________________________ Fax: _______________________________

IACUC Protocol Title: ____

IACUC Number: ___________________________________ Approval Date: __________________________

IBC Number: _____________________________________ Approval Date: __________________________

Bill To:____ Telephone:_______________________________

Address:____ Department:_____________________________

Purchase Order #:________________________ Email: _____________________ Fax: __________________

Mouse Line(s) Identification Number(s): ____

Where will the animals be housed? Facility: ______________________________ Room number:__________

Would the proposed number of embryos transferred be sufficient for your lines? ☐ Yes ☐ No

If “No”, please explain: ____

____

____

____

____

____

Investigator’s Signature: _____________________________________ Date: _______________

TCMF STAFF ONLY
Received by: ____ Date: _______________

TRANSGENIC & CHIMERIC MOUSE FACILITY

Location: 38 Clinical Research Building
Tel: 215/573-3023; 215/746-6392
Fax: 215/573-5892
Web: *http://www.med.upenn.edu/tcmf*

Mailing Address:
502 Clinical Research Building
415 Curie Boulevard
Philadelphia, PA 19104-6145

Sperm Cryopreservation Request Form

Investigator:_____________________ Department: _____________________

Address: _____________________ Email: _____________________

Telephone: _____________________ Fax: _____________________

Contact Person: _____________________ Email: _____________________

Telephone: _____________________ Fax: _____________________

IACUC Protocol Title: ____

IACUC Number: _____________________ Approval Date: _____________________

IBC Number: _____________________ Approval Date: _____________________

Business Administrator:_____________________ Telephone:_____________________

Address:_____________________ Department:_____________________

Purchase Order #:______________ Email: ______________ Fax: ______________

Mouse Line(s) Identification Number(s): ____

Where will the animals be housed? Facility: _____________________ Room number:____________

Will you require training in organ harvesting? ☐ Yes ☐ No
(If "Yes", please contact the Facility at 573-3023 to make arrangements for training.)

Investigator's Signature: _____________________ Date: ____________

TCMF STAFF ONLY
Received by: _____________________ Date: ____________

TRANSGENIC & CHIMERIC MOUSE FACILITY

Location: 38 Clinical Research Building
Tel: 215/573-3023; 215/746-6392
Fax: 215/573-5892
Web: *http://www.med.upenn.edu/tcmf*

Mailing Address:
502 Clinical Research Building
415 Curie Boulevard
Philadelphia, PA 19104-6145

In-Vitro Fertilization Request Form

Investigator:____ Department: ____________________________________

Address: ____ Email: ____

Telephone: ____ Fax: ____

Contact Person: ____ Email: ____

Telephone: ____ Fax: ____

IACUC Protocol Title: ____

IACUC Number: ____ Approval Date: __________________________________

IBC Number: ____ Approval Date: __________________________________

Bill To:____ Telephone:______________________________________

Address:____ Department:_____________________________________

Purchase Order #:_____________________________ Email: __________________________ Fax:______________________

Mouse Line(s) Identification Number(s): ____

Where will the animals be housed? Facility: ____ Room number:____________

Will you require training in organ harvesting? ☐ Yes ☐ No
(If "Yes", please contact the Facility at 573-3023 to make arrangements for training.)

Investigator's Signature: ____ Date: ________________

TCMF STAFF ONLY
Received by: ____ Date: ________________