

**For Office Use Only:**  
Application Rec'd \_\_\_\_\_  
Human Subjects Rec'd \_\_\_\_\_  
CHTN Database \_\_\_\_\_  
Networked to CHTN Y N  
E-mail to CHTN \_\_\_\_\_  
Fax App. To CHTN \_\_\_\_\_



**Tissue Procurement Shared Resource**  
The Ohio State University  
Polaris Innovation Centre  
2001 Polaris Parkway  
Columbus, OH 43240  
Ph: (614) 293-5493 • Fx: (614) 293-7013

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**OSU COMPREHENSIVE CANCER CENTER  
TISSUE PROCUREMENT SHARED RESOURCE  
APPLICATION FOR TISSUE OR FLUID FOR RESEARCH USE**

**I. INFORMATION AND DIRECTIONS**

The Tissue Procurement Shared Resource (TPSR) is part of the OSU Comprehensive Cancer Center (CCC) Study Grant, funded by the National Cancer Institute (NCI). TPSR procures remnant surgical and autopsy tissues or fluids for individual researcher protocols and for approved clinical trials. TPSR currently procures from OSU Hospital, The Arthur G. James Cancer Hospital and Solove Research Institute. According to the by-laws of the OSU Hospital and the Arthur G. James Cancer Hospital and Solove Research Institute, all tissues must be sent to pathology for evaluation. During the gross evaluation, TPSR technical staff works with the anatomic pathology staff to procure the tissue(s) for your request(s) to ensure you receive remnant, non-diagnostic specimens of the highest quality. At no time is patient diagnosis compromised. The following information requested in these forms is required to correctly document your requests for tissues and fluids. When submitting your request for services please type or print neatly.

A. Patient identity is confidential. Specimens will be coded and assessed a processing fee of:

i. CCC Member: \$25/tissue

B. Investigators must have human use approval to receive tissues from the TPSR. Approval can be obtained from the OSU Institutional Review Board (Human Subjects Committee, <http://www.orrp.ohio-state.edu/>). **A COPY OF YOUR HUMAN SUBJECTS APPROVAL SHOULD BE ATTACHED TO YOUR COMPLETED APPLICATION.** Please note, an annual human subject's review is performed by the OSU Office of Responsible Research Practices (ORRP). You must forward an updated approved copy of your IRB to TPSR prior to the expiration date in order to maintain your eligibility to receive tissue. If you have questions, please call the OSU IRB at 292-9046.

C. The TPSR also provides fresh or frozen non-diagnostic tissues requested as part of a clinical trial. Please indicate this below and note that for tissue to be released and identified to a clinical trial, a copy of the signed informed consent with investigator name and protocol number must be faxed to the TPSR office (293-7013).

D. The OSU Tissue Procurement Service also serves as the Midwestern Division of NCI's Cooperative Human Tissue Network (CHTN). The CHTN is a national network of six institutions that work together to provide tissues and fluids to research investigators. Participating CHTN divisions include the University of Alabama at Birmingham (Southern Division), the Hospitals of the University of Pennsylvania (Eastern Division), Vanderbilt University (Western Division), University of Virginia (Mid-Atlantic Division) and the Pediatric Division, which is located at Nationwide Children's Hospital, Columbus, Ohio. As a component of the CHTN, the OSU Midwestern Division also procures tissues from consortiums located at the Cleveland Clinic and Case Western Reserve University. In consultation with our staff it may be determined that our local tissue resource will not be able to serve your tissue requests in a time frame you anticipate.

E. You can increase your access to tissues, increase the patient demographic base from which tissues are provided, or limit the area of procurement by selecting from the choices below. By making one of these selections below you are asking to become a CHTN member and therefore an additional but separate CHTN application must also be sent with your OSU CCC application. An additional "Data Use Agreement" will need to be signed by you and included in your application. The CHTN Tissue Request Application can be downloaded from the NCI website (<http://www-chn.ims.nci.nih.gov>). Please contact our offices (293-5493) if you need help with the CHTN application. **If you make no selection below, the procurement locations for your requests will default to OSU Hospital, James Cancer Hospital & Solove Research Institute.**

i.  I would like to receive tissues from the Cleveland Clinic and Case Western Reserve University sites funded through the CHTN. I understand the costs for these tissues are \$40/specimen. However, I understand I will not pay shipping charges for these specimens, which is a savings compared to other CHTN sites.

ii.  I would like to have my specific request(s) networked to all other CHTN divisions and will pay \$40/specimen plus shipping costs.

**II. SPECIMENS WITH PATIENT INFORMED CONSENT**

Specimens procured from the OSU procurement sites are anonymized and carry no identifiers to match a patient with the specimen. If it is a requirement that you need to have the patient identified to the specimen, the TPSR Office must receive a patient signed informed consent associated with your approved IRB application before this linkage can be made available. Please discuss this procedure with our staff.

**III. INVESTIGATOR DATA**

A. Principal Investigator: \_\_\_\_\_  
Last Name First Name Middle Initial Degree

Investigator's Title: \_\_\_\_\_

Primary Mailing Address (Street/Bldg./Room#): \_\_\_\_\_

Department: \_\_\_\_\_

Institution: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone (Day): \_\_\_\_\_ (Nights/Weekends): \_\_\_\_\_

Fax number at which you may be notified: \_\_\_\_\_ E-mail: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Lab/Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

B. Laboratory Address Where Tissue Will Be Stored (*if different from above*):

Department: \_\_\_\_\_

Street/Bldg./Room#: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**Applications must include a valid (active) department or research account number. Specimens that have been distributed will be billed to the designated account number. For tracking purposes please include the billing address or administrative office where the copies of the invoices and associated specimen list can be mailed. Applications will not become active until this information is provided.**

**Account Number: \_\_\_\_\_ (This must be completed, before the request is activated).**

Billing Address (*if different from above*):

Department: \_\_\_\_\_

Street/Bldg./Room#: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**IV. FUNDING INFORMATION**

Tissues will be provided to investigators on a priority basis in the following priority order:

- 1. Comprehensive Cancer Center Members
- 2. Non CCC Members

If you are a CCC member, please list the CCC program(s) with which you are affiliated:

\_\_\_\_\_

A. Please include presently funded research grant(s) and the sponsor(s). If you are currently unfunded, please indicate below "unfunded" or if you are funded through OSU or your department, please indicate "OSU institutional funding":

While we try to provide specimens for all requests, if a choice must be made at the time of procurement, NIH/NCI funding will receive priority. You may attach other documents that list your funding.

Funding Source (Include grant number)

Period of Support

- B. Please provide the title and a short research summary (abstract) of the proposed research on the tissues you are requesting from Tissue Procurement Service (*use a separate page or preferably email us an electronic copy of your abstract to [scott.jewell@osumc.edu](mailto:scott.jewell@osumc.edu) or [laurie.johnson@osumc.edu](mailto:laurie.johnson@osumc.edu)*).

V. **TYPE OF RESEARCH: This application is requesting tissue for...**

A. **BASIC RESEARCH (using anonymized specimens)**

B. **BASIC RESEARCH (with investigator gathered patient informed consent)**

C. **CLINICAL TRIAL (requires informed consent)** , **Clinical Trial Protocol Number:** \_\_\_\_\_

VI. **SERVICES REQUESTED (Please copy this page as needed for multiple requests.)**

A. **Human Tissue Specimen Criteria**

1. Anatomic Site or Tissue Type: \_\_\_\_\_
  - a)  Malignant;  Benign;  Uninvolved;  Diseased;  Other: \_\_\_\_\_  
If malignant is selected, please specify:  Primary and/or Metastasis;  Primary only;  Mets only  
 Any malignant OR specify type of malignancy: \_\_\_\_\_
2. Is matched normal tissue from the same patient required?  Yes;  No;  If available
3. Will you accept tissue from patients previously treated with:  Radiation;  Chemotherapy
4. Must specimen be sterile?  Yes;  No;  As clean as possible
5. Gender:  Male;  Female;  Either
6. Tissue Source:  
 Surgical: Must be frozen within \_\_\_\_ hours of resection, OR  time constraint not applicable  
 Autopsy: Must be collected within \_\_\_\_ hours after death
7. Patient limitations (i.e. age, race, or other limiting characteristics): \_\_\_\_\_
8. Amount of tissue required (minimum to maximum size or dimension): \_\_\_\_\_
9. Frequency tissue is needed: \_\_\_\_\_
10. Total number of specimens needed: \_\_\_\_\_
11. Requested starting date to receive tissue: \_\_\_\_\_

B. **Preparation and Preservation of Specimens (please mark only those that apply)**

- Fresh** Indicate media requirements: \_\_\_\_\_  
\_\_\_\_ Transport Media; \_\_\_\_ PBS/Saline; \_\_\_\_ Dry; \_\_\_\_ Other: \_\_\_\_\_  
(If preference for transport media, i.e. RPMI, Hanks, MEM, please indicate): \_\_\_\_\_  
Wrap in PBS wet gauze?  Yes;  No  
Add supplements:  
 Antibiotics (indicate type & amount) \_\_\_\_\_  
 Fetal Calf Serum (indicate percentage) \_\_\_\_\_  
 Fungizone (indicate amount) \_\_\_\_\_

**Frozen** Indicate freezing requirements (i.e. snap frozen by liquid nitrogen, frozen by -80C conditions, in OCT media (used for frozen sectioning), etc.): \_\_\_\_\_

**Fixed** Indicate fixative requirements (10% neutral buffered formalin (NBF), gluteraldehyde, etc.). If you have your own fixative you wish for us to use, we will ask you to supply this): \_\_\_\_\_

C. I would like quality control (*paraffin block and H&E slide*) done on my tissues (\$7.00 extra)

D. **Specimen Information Required:** (*Anatomic site of tissue, provisional diagnosis, final diagnosis, patient age, sex and race [if available] will be provided for all specimens.*) Please list any additional information requirements and the reason for your request: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**NOTE:** It is the investigator's responsibility to notify TPSR if a request changes. Please contact TPSR at 614-293-6079 to request changes. Otherwise, until notified that a request is inactive, TP Service will collect tissue for the investigator and the investigator will be charged the processing fee.

## ADDITIONAL SERVICES

### LASER CAPTURE MICRODISSECTION SYSTEM

The Laser Capture Microdissection System is a component of the TPSR and available on a priority basis to CCC investigators. To schedule use of the LCM, access the LCM Scheduler at <http://pathology.osu.edu/lcm/>. Questions on LCM training and payment, please contact Dr. Kurtis Yearsley, 293-0537 or by email [kurtis.yearsley@osumc.edu](mailto:kurtis.yearsley@osumc.edu).

### PATHOLOGY CORE FACILITY

The Pathology Core Facility (PCF) is a service provided by the Department of Pathology and will accept requests for histology services including immunohistochemistry. To utilize this service, please contact the PCF by phone 614-293-3938 or at <http://www.pathology.osu.edu/htrn/pcf/default.asp>.

## AGREEMENT

The recipient hereby agrees that the tissues to be provided by Tissue Procurement Share Resource (TPSR) will be used only for the research purposes specified in this application; that no attempt will be made to learn the identity of other information about the subjects providing tissue; and that tissues and their products shall not be sold (or distributed free of charge) to third parties, nor used to produce commercial products (including the production of cells or cell products for sale).

We understand that while the TPSR attempts to avoid supplying tissues contaminated with highly infectious agents such as hepatitis and HIV, all tissues should be handled as if potentially infectious. The recipient acknowledges that he/she is aware of and follows OSHA regulations for handling human specimens and will instruct their staff to abide by those rules. The recipient further agrees to assume all responsibility for informing and training personnel in the dangers and procedures for safe handling of human tissues.

Tissues are provided as a service to the research community without warranty of merchantability or fitness for a particular purpose or any other warranty, express or implied. TPSR accepts no responsibility for any injury (including death), damages or loss that may arise either directly or indirectly from their use.

The recipient hereby agrees to acknowledge the contributions of the Tissue Procurement Shared Service in all publications resulting from the use of these tissues. Recommended wording to the methods or acknowledgement section is as follows: *Tissue samples were provided by the Tissue Procurement Shared Resource at The Ohio State University Comprehensive Cancer Center, Columbus, Ohio. This service is funded by the National Cancer Institute, grant P30 CA16058.*

BY MY SIGNATURE I AGREE TO THE TERMS SET FORTH IN THE ABOVE AGREEMENT

\_\_\_\_\_  
Name of Investigator

\_\_\_\_\_  
Signature of Investigator

\_\_\_\_\_  
Date

**UPON RECEIPT OF THESE SIGNED UNDERSTANDINGS AND THE INFORMATION REQUESTED ABOVE, TISSUE PROCUREMENT WILL CONSIDER THIS REQUEST AND ALL FUTURE REQUESTS FOR TISSE. Specific questions about your application should be directed to the Tissue Procurement Division, 614-293-5493.**

Revised 1/11/2007

CCC Application for Tisses.doc