

Core Facility Authorization Form

Primary Investigator

Name _____
Addr _____

Tel _____
Email _____

Core Services Requested

- | | | |
|--|--------------------------------------|--|
| <input type="checkbox"/> Biostatistics | <input type="checkbox"/> Cancer Risk | <input type="checkbox"/> Genome |
| <input type="checkbox"/> Immunohistochem. | <input type="checkbox"/> Informatics | <input type="checkbox"/> Lab for Cell Analysis |
| <input type="checkbox"/> Mass Spectrometry | <input type="checkbox"/> Microarray | <input type="checkbox"/> Mouse Pathology |
| <input type="checkbox"/> Preclin. Therapeutics | <input type="checkbox"/> Tissue | <input type="checkbox"/> Transgenic |

Requested usage: 6 mos 1 yr 2 yrs — *or* —
Starting: _____ Ending: _____

Lab Manager

Name: _____
Address: _____

City/State/Zip _____
Tel: _____ Fax: _____
Email: _____

Account Administrator

Name: _____
Address: _____

City/State/Zip _____
Tel: _____ Fax: _____
Email: _____

Ship to information

Ship To:
Attn: _____
Address _____
Address _____
Address: _____
City: _____ State/Province: _____ Zip Code: _____
Country: _____ (if not US)

Billing information

Tracking/PO #: _____
Bill To: _____
Address _____
Address _____
Address: _____
City: _____ State/Province: _____ Zip Code: _____
Country: _____ (if not US)

Additional users:

User 1 - Name _____	User 2 - Name _____
Tel _____ Email _____	Tel _____ Email _____
User 3 - Name _____	User 4 - Name _____
Tel _____ Email _____	Tel _____ Email _____

Conditions of Use

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Authorized Signature (must be PI or equivalent): _____ Date: _____

Submit by fax to 415-353-9728. For questions, contact coreadmin@cc.ucsf.edu.

ACCOUNT: NEW REVISIONS