

RELEASE OF GROSS ORGANS FOR TEACHING SESSION

Please email completed form to UCD_AMC_SOMTeachingSpecimens@ucdenver.edu

You will receive a confirmation email once approved. Please allow up to a 2 week's notice for processing.

Today's Date: _____ Check this box if this event will take place in an MPL

***If event is in an MPL, organs will be placed in room at time of event.**

Date and Time You Will Pick Up Organs: _____

***Organ Pick-Up Hours are Monday-Friday 8:30 am-12:00pm and 1:00pm-3:30 pm**

Materials requested (please provide specifics: such as what organs or organ systems are needed, what specific disease processes/diagnoses are requested, whether "normal" organs are needed for comparison, and the number of examples needed for the educational activity):

I am assuming responsibility for gross organs pulled from the teaching collection of the University Of Colorado School Of Medicine. I certify that they will be used exclusively for educational purposes and will be returned to the School in the condition that they were borrowed at the conclusion of the educational activity. NO YES

I also understand that these organs have been fixed in 10% formalin and Jores II solution and can be hazardous with prolonged exposure. NO YES

I will take all necessary precautions when showing and handling these organs by the use of PPE (Personal Protective Equipment) and also understand organs will be given to me in a diluted solution that will be safe for temporary storage and travel. NO YES

I understand that I assume all liabilities once the organs have been released to me until such time as they have been returned. NO YES

Location of event: _____

Start date of event: _____

End date of event: _____

Date and time organs are to be returned: _____

Requestors Phone Number: _____

Requestors E-mail: _____

Requestors Printed Name: _____

Requestors Job Title: _____

Requestors Signature: _____

SUBMIT FORM

LABORATORY STAFF ONLY

Signature of Physician BRAIN REQUESTS:

APPROVED DENIED

Signature of Physician ORGAN REQUEST:

APPROVED DENIED

SUBMIT FORM TO LAB

PRINT NAME OF LAB STAFF THAT PREPARED BUCKET/S:

SIGNATURE OF REQUESTOR PICKING UP:

DATE: _____ **TIME:** _____

DATE ORGANS RETURNED: _____ **TIME:** _____

SIGNATURE OF LAB STAFF: _____

SIGNATURE OF REQUESTOR: _____