ROCKY MOUNTAIN LIONS EYE BANK
Share the circle of light

Request for Ocular Tissue for Research and Training

Name _____

Phone_____ Fax_____ Email_____

☐ Current resident at the University of Colorado Health Sciences Center

☐ Current faculty or staff at the University of Colorado Health Sciences Center

Use of tissue_____

Is this a funded research project? ☐ YES ☐ NO

Date tissue is needed _____

If outside of the Denver metropolitan area, include shipping instructions (shipping fees apply)

_____

_____

_____

Tissue Requested

TISSUE	QUANTITY	LENS PREFERENCE	SPECIAL REQUIREMENTS
Fresh Whole Globe		□ aphakic □ pseudophakic □ phakic □ no preference	
Cornea		□ aphakic □ pseudophakic □ phakic □ no preference	
Other		□ aphakic □ pseudophakic □ phakic □ no preference	

□ Check here if donor serology is required. List necessary tests (provided with additional fees, fee schedule available)

_____

_____ _____

Signature *Date*

_____ _____

Faculty Signature (required for requests from ophthalmology residents) *Date*

Email completed form to distribution@corneas.org or fax to 720-848-3947