

NEWBORN SCREENING SPECIMEN REQUEST FORM FOR DE-IDENTIFIED SPECIMENS

(Public Health Research / Test Development)

- 1. Requestor/Title/Institution:**
- 2. Phone Number:**
- 3. Contact, if different from the Requestor:**
- 4. Contact's Phone Number:**
- 5. Date of Request:**
- 6. Date Required:**
- 7. Number of Specimens:**
- 8. Information regarding specimens (gender, maternal age, location of infant i.e. zip code if >20 in category, disorder/analyte, etc.):**
- 9. Spot Size/Number of Punches per Infant (one full circle must remain on the card; if there is insufficient blood, the sample is considered ineligible for study):**
- 10. Preparation (e.g. the arrangement of samples on the plate (Investigators are asked to supply tubes/plates; the arrangement of vacant wells for controls; request for DNA extraction, if applicable. Fee may be assessed depending on amount of preparation and/or number of specimens).**
- 11. Study title / Description / Protocol number / Rationale for request:**

12. Requestor Attestation:

I affirm that the above information is accurate and the requested specimens will be used for the exempt and/or currently approved IRB study above (see #11):

Signature:_____Date:_____

13. Verification by Requestor's IRB if Requestor's Institution is not NYSDOH:

Check box that applies:

Study is exempt and not subject to IRB review at this institution

Study was last approved by this IRB on (date): _____

I affirm that the requested specimens and their use are consistent with the objectives of this study (<<insert number and title>>):

IRB Program Staff

Name _____ **Title:** _____

Signature: _____ **Date:** _____

14. Verification by NYSDOH IRB:

This specimen request is consistent with the objectives of study (<<insert number and title>>).

Study last approved by IRB on (date): _____

IRB Program Staff

Name: _____ **Title:** _____

Signature: _____ **Date:** _____

15. Approval of Request for Specimens, Newborn Screening Program:

NBS Program Staff Name: _____ **Title:** _____

Signature: _____ **Date:** _____

16. Fulfillment:

NBS Program Staff Name: _____ **Title:** _____

Signature: _____ **Date:** _____

17. Fee: _____ **18. Specimen linkage destroyed date:** _____

Signature: _____