

**INSTITUTIONAL ANATOMICAL OVERSIGHT REVIEW
COMMITTEE**

IAORC Chairman: Catherine G. Ambrose, Associate Professor, Department Of Orthopedic Surgery
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REQUEST FOR USE OF ANATOMICAL SPECIMENS

TITLE OF PROJECT: _____

PROJECT COORDINATOR: _____
(must be MD, PhD, or faculty level equivalent)

DEPT/DIVISION: _____ E-MAIL ADDRESS: _____

TELEPHONE: (Daytime) _____ (Evening) _____ (Pager) _____

OTHER KEY PERSONNEL:

Name	Title	School	Dept/Division	Phone

START DATE OF PROJECT _____

DESCRIPTION OF PROJECT (include objectives for education or research):

Yes No

NUMBER AND DESCRIPTION OF ANATOMICAL SPECIMENS: EMBALMED?

SOURCE OF ANATOMICAL SPECIMENS:

DESCRIPTION OF PHYSICAL LOCATION, STORAGE AND SECURITY MEASURES:

PROGRAM FUNDING:

If UTHSC source, enter Chart String: _____

FOR COMMITTEE USE

Project # _____ HSF Approval _____