

**COMPARATIVE MEDICINE LABORATORY ANIMAL FACILITIES
CONTROLLED/NON-CONTROLLED SUBSTANCES REQUEST FORM**

Principal Investigator: _____ Phone #: _____ Date: _____

Name of Drug (include generic name): _____ Quantity: _____ Unit Type: _____

Name of Drug (include generic name): _____ Quantity: _____ Unit Type: _____

Purpose: _____

Location (where drug will be used): _____ Duration of Project: _____

Storage Location: _____ DEA Approved Cabinet: Yes No

IACUC Project #: _____
Authorized Signature (P.I. or Department Chairman)

Person Picking Up Drug: _____
Signature of Person Picking Up Drug

Date drug picked up by Principal Investigator: _____

NOTE: Usage inventory must be maintained on controlled substances. Unused drug and inventory sheets must be returned to the Laboratory Animal Facilities at 204 BEB (technician's office).

Approved by: _____ Date: _____ Issued By: _____ Date: _____

Comments: _____ Billed by: _____ Date: _____
1/03

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