

# CLINICAL CASE REQUEST

**Date:** \_\_\_\_\_ **Species:** \_\_\_\_\_ **Room Number:** \_\_\_\_\_

**Location: (circle appropriate one)**

CMV-LAF	Medical Center
Cherokee A	Jessie Harris
Walters Life Sciences	Satellite _____ (name)

**Protocol Number:** \_\_\_\_\_ **Principal Investigator:** \_\_\_\_\_

**Reported By:** \_\_\_\_\_

**Description of Problem:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**Other Information:** \_\_\_\_\_  
\_\_\_\_\_

Please fill out each time a clinical case is started and send to OLAC at [olac@utk.edu](mailto:olac@utk.edu) or fax to the OLAC office (974-5649). Thank you

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