FREEZER TEMPERATURE MAINTAINED AT:

Click here to enter text.

*Instructions:*

1. *Complete information requested below for Curiteva to be able to consign frozen tissue to the facility.*

|  |  |
| --- | --- |
| **CUSTOMER INFORMATION** | |
| **Facility Name:** Click here to enter text. | **Address:** Click here to enter text. |
| **Phone Number:** Click here to enter text. | **City, State, Zip Code:** Click here to enter text. |
| **Contact Name:** Click here to enter text. | **Contact Email:** Click here to enter text. |

Click here to enter text.

Hereby certifies that all frozen human allograft tissue received from Curiteva will be maintained and stored in our facility according to the source facilities’ specifications under the following conditions:

* Frozen Cellular products and CuriGraft Viable Cellular Bone Allograft have been maintained at - 65°C or colder (acceptable range) at all times since the date of receipt.
* Frozen human tissue has been stored in a monitored freezer.
* Frozen human tissue has been stored in a freezer equipped with an alarm system that alerts hospital staff should the temperature fall outside of acceptable range.
* Frozen human tissue has not been returned to a frozen state after having been thawed or stored outside of the acceptable temperature range.

*\*\*While it is not our normal policy to accept returns for frozen tissue, we understand there may be extenuating circumstances that will require us to do so. Prior to making this determination, we will need to ensure that a Freezer Certification Form is on file and signed by the authorized personnel of the requesting facility.*

Click here to enter text.

Understands that it is the facility’s responsibility to ensure proper shipment of frozen tissue on dry ice as per Curiteva’s return policy.

**Signature: Date:**

**Name (Printed): Title:**