Request for Special Treatment or Procedure Form

PRINCIPAL INVESTIGATOR _____

ACUC APPROVED PROTOCOL # _____

PROTOCOL EXPIRATION DATE _____

ANIMAL HOUSING LOCATION* (Bldg and room number; list all applicable locations)_____

DESCRIPTION OF TREATMENT/PROCEDURE (*including frequency and duration, if applicable*)

RATIONALE

RESPONSIBLE PERSONNEL

Contact	Name	Email	Emergency phone #
Primary			
Secondary			
Add rows as needed			

By signing below, you certify that these treatments/procedures are approved in your ACUC protocol or protocol amendment:

Name:	Date:
Signature:	