

SickKids-UHN TMDT FLOW CYTOMETRY FACILITY

24 HOUR ACCESS REGISTRATION FORM

User Name _____

E-mail _____

PI Name _____

E-mail _____

Dept/Program _____

User Telephone# (Lab) _____

Office _____

Principal Investigator:

Please indicate by your signature that you authorize:

- 1) The above named member of your lab to use the Flow Cytometry Facility (FCF) outside of normal working hours and on weekends.
- 2) The FCF to bill the above cost center for any time used, loss of access card

Signature of Principal Investigator

Date

FCF User:

Please indicate by your signature that you agree to:

1. Standard Operating Procedures and Policies for **24 HOUR ACCESS**.
2. Not lend your card to any other user.
3. Not to lend your security card to other people so that they access the FCF facility.

Failure to do so may result in barring your further use of our instrumentation and services, and may also result in additional charges for repairs.

Signature of User

Date