NIH CRM Cell Deposit Form

The following documents must accompany your submission:

- Completed deposit form
- Characterization documentation (see Section 3 below)
- A copy of protocols used to culture the cell line (see Section 4 below)

Additional pages may be added to expand on answers, marking each response with the question number.

All documents may be submitted either electronically or by mail.

Electronically:
Email to: nihcrm@mail.nih.gov

Subject: Cell Deposit Form

Mail:
NIH Center for Regenerative Medicine
50 South Drive, Room 1139
MSC 8024
Bethesda, MD 20892 USA

SECTION 1: Cell Provider Details			
Depositor Name:			
Institution/Organization:			
Address:			
Telephone:		Fax:	
E-mail:			
Owner of cell line: *(if different from depositor)*			
Name of person with authority to issue the Material Transfer Agreement:			
Address:			
Telephone:		Fax:	
E-mail:			

SECTION 2: Cell Line Details	
Cell Line Name:	
Donor Age:	
Donor Gender:	Male Female
Donor Ethnicity:	
Donor Blood Type:	A B AB O Unknown
Normal: *(if no, provide disease details)*	Yes No
Cell Type: *(if iPSC or iPSC derived cell line, complete the following:)*	
• Reprogramming Method: *(please specify genes used)*	
• Somatic Starting Material:	
• Are donor cells or starting material available?	Yes No
• Were the cells derived in a clinically compliant manner?	Yes No Unknown
• Are gene insertions present in the reprogrammed cell? *(List methods used to confirm absence or presence of gene insertion events)*	Yes No Unknown
Passage Number:	
Population Doubling Time: *(In Recommended Culture Conditions – from Section 4)*	
Date Derived: *(if iPSC derived cell line, include iPSC derivation date and passage number at differentiation)*	
Genetic Modifications: *(if yes, please attach a map or provide a list of the elements in the genetic modifications, how they were created or obtained, and whether the depositing institution/organization has intellectual property rights to these elements.)*	Yes No
Reporters: *(if yes, provide details including any elements protected as intellectual property)*	Yes No

SECTION 3 : Characterization Details			
Test Name	**Required Result**	**Testing Performed**	
Mycoplasma detection (method)	Negative	Yes	No
Sterility assessment	Sterile	Yes	No
Karyotype		Yes	No
Identity (STR)		Yes	No
Human Virus Testing		Yes	No
MAP		Yes	No
Bovine pathogens		Yes	No
Porcine pathogens		Yes	No
In Vivo (in apparent Viruses)		Yes	No
28 Day In Vitro		Yes	No
Co-cultivation		Yes	No
ABO/Rh		Yes	No
HLA		Yes	No
FACS		Yes	No
Embryoid Body		Yes	No
Teratoma		Yes	No
Whole genome sequencing		Yes	No
Epigenic Analysis		Yes	No
Other tests		Yes	No
Please attach any relevant documentation of the characterization details.			

SECTION 4: Culture Conditions			
Were the cells co-cultured? *(if yes, complete the following 4 questions)*		Yes	No
• Identify supporting cells			
• During derivation process			
• Currently			
• Are the supporting cells commercially available			
Attachment Substrate/Matrix			
Culture Medium			
Passage Reagent			
Freezing Medium and Method			
Details of critical culture conditions *(please attach main culture protocols)*:			

SECTION 5: Consent Information *If redacted consent form is available, please attach.*	
Is a redacted copy of the consent available? *(if yes, please attach)*	Yes No
Do you have access to data that could link the cells back to the donor?	Yes No
Can the donor be re-contacted?	Yes No
Check all that apply:	
For Research Purposes	
For Commercial Purposes	
For Therapeutic Purposes	
Are there any restrictions on the use of the cell lines? *(if yes, provide details)*	Yes No
Is there any available medical information on the donor(s), including infection disease screening? *(if yes, provide details)*	Yes No
Is there any available clinical, observational, or diagnostic information about the donor?	Yes No

SECTION 6: Related Publications
Are there any publications related to this line? If yes, please list:

SECTION 7: Declaration By submitting this deposit for the NIH Center for Regenerative Medication, I certify that the statements and Assurance herein are true, complete, and accurate to the best of my knowledge.	
Signed on behalf of Host Institution *(Person responsible e.g., Scientific Director/Department Head)* x Date:	Signed by Cell Line Provider: *(Person listed in Section 1)* x Date:
Name and title of Signatory for Institution/Organization:	
Address of Institution/Organization: *(if different than address in Section 1)*	