REQUEST FOR ASSISTANCE TO INTERNATIONAL COURIERS TRANSITING THROUGH PARIS AIRPORTS WITH AN UNRELATED STEM CELL PRODUCT

COURIER INFORMATION Today's date: ____ /____ /_____

☐ Mr ☐ Ms ☐ Dr LAST NAME : First Name:

PRODUCT TRANSPORTED

☐ Bone Marrow
☐ Peripheral Blood Stem Cells (PBSC)
☐ Lymphocytes

DATE(S) OF TRAVEL

(1) _____/_____/_____ *(day/month/year)*

(2) _____/_____/_____ *(if PBSC)*

COLLECTION CENTRE

Name : _____
Location (city): _____
Country: _____

TRANSPLANT CENTRE

Name : _____
Location (city): _____
Country : _____

TRAVEL ITINERARY WITH THE PRODUCT **TRAVEL DATE:** ____ /____ /_____

Please specify the name of the Paris airport (CDG or ORY)

Airline: _____ Flight: _____ Airport:_____ Departing from: _____ at: _____ h _____ Arriving to: _____ at: _____ h _____	Airline: _____ Flight: _____ Airport:_____ Departing from: _____ at: _____ h _____ Arriving to: _____ at: _____ h _____	Airline: _____ Flight: _____ Airport:_____ Departing from: _____ at: _____ h _____ Arriving to: _____ at: _____ h _____

1st BACK-UP FLIGHTS **TRAVEL DATE:** ____ /____ /_____

Airline: _____ Flight: _____ Airport:_____ Departing from: _____ at: _____ h _____ Arriving to: _____ at: _____ h _____	Airline: _____ Flight: _____ Airport:_____ Departing from: _____ at: _____ h _____ Arriving to: _____ at: _____ h _____	Airline: _____ Flight: _____ Airport:_____ Departing from: _____ at: _____ h _____ Arriving to: _____ at: _____ h _____

2nd BACK-UP FLIGHTS **TRAVEL DATE:** ____ /____ /____

Airline: _____ Flight: _____ Airport:_____ Departing from: _____ at: _____ h _____ Arriving to: _____ at: _____ h _____	Airline: _____ Flight: _____ Airport:_____ Departing from: _____ at: _____ h _____ Arriving to: _____ at: _____ h _____	Airline: _____ Flight: _____ Airport:_____ Departing from: _____ at: _____ h _____ Arriving to: _____ at: _____ h _____

CONTAINER

Type of container: ☐ **Isotherm Box** ☐ **Other (please specify)**: _____
Transportation criteria: ☐ At room temperature ☐ Cooled with Ice Packs

PLEASE SPECIFY CONTACT NAME AND FAX NUMBER TO CONFIRM RECEPTION: + _____

DOCUMENT TO BE FAXED DULY COMPLETED TO FRANCE GREFFE DE MOELLE REGISTRY ONLY 48 HOURS IN ADVANCE **FAX: +33-1 49 98 37 14**

❑ **RECEIVED AT FGM Registry** on: ____ /____ /_____ by: _____