

Appendix C

Exclusion Criteria

Known HIV Infection

Known HBV Infection

Still Birth

No Consent from Mother

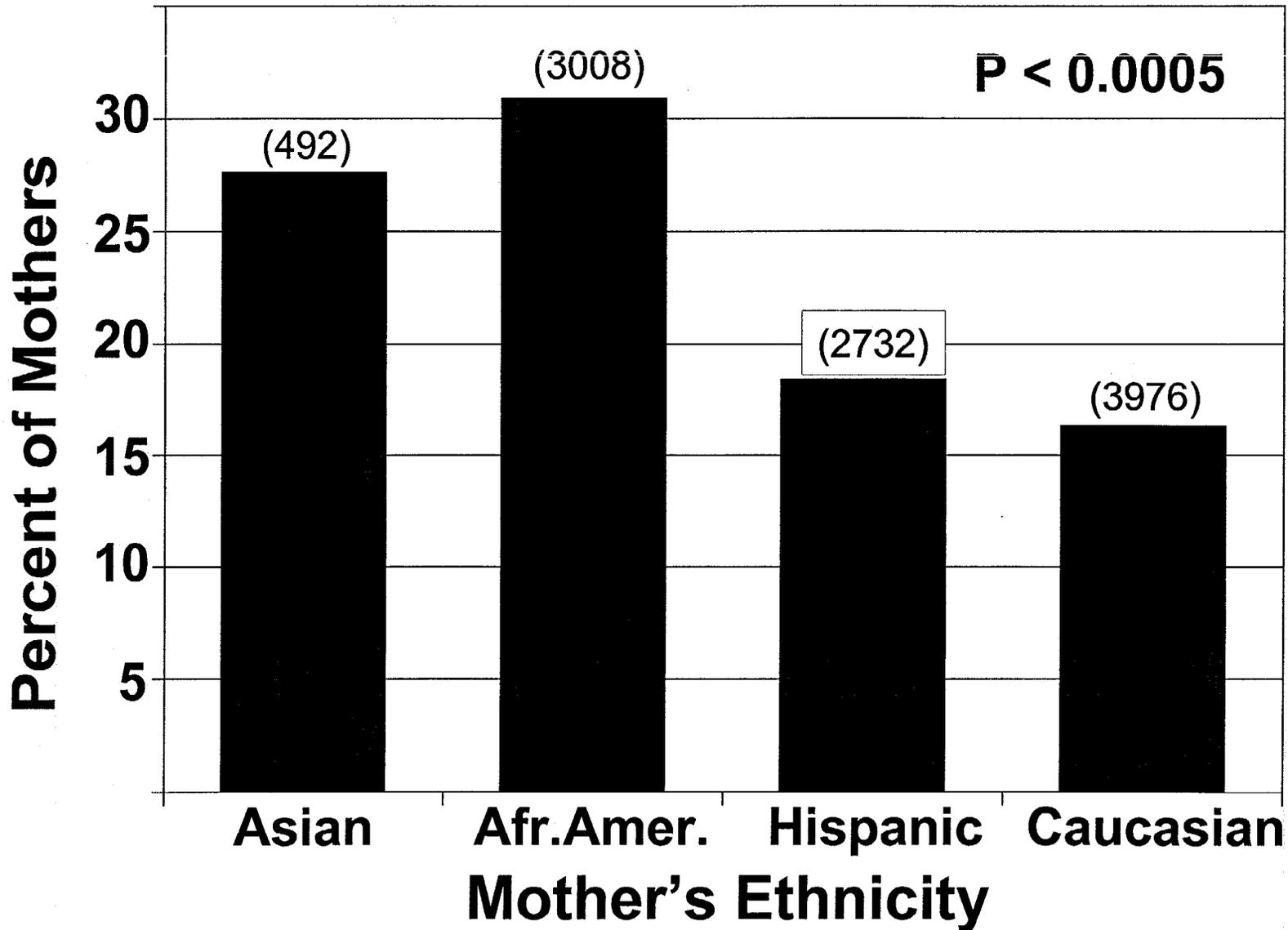
Transplantable Genetic Disease

Collected Blood Volume:

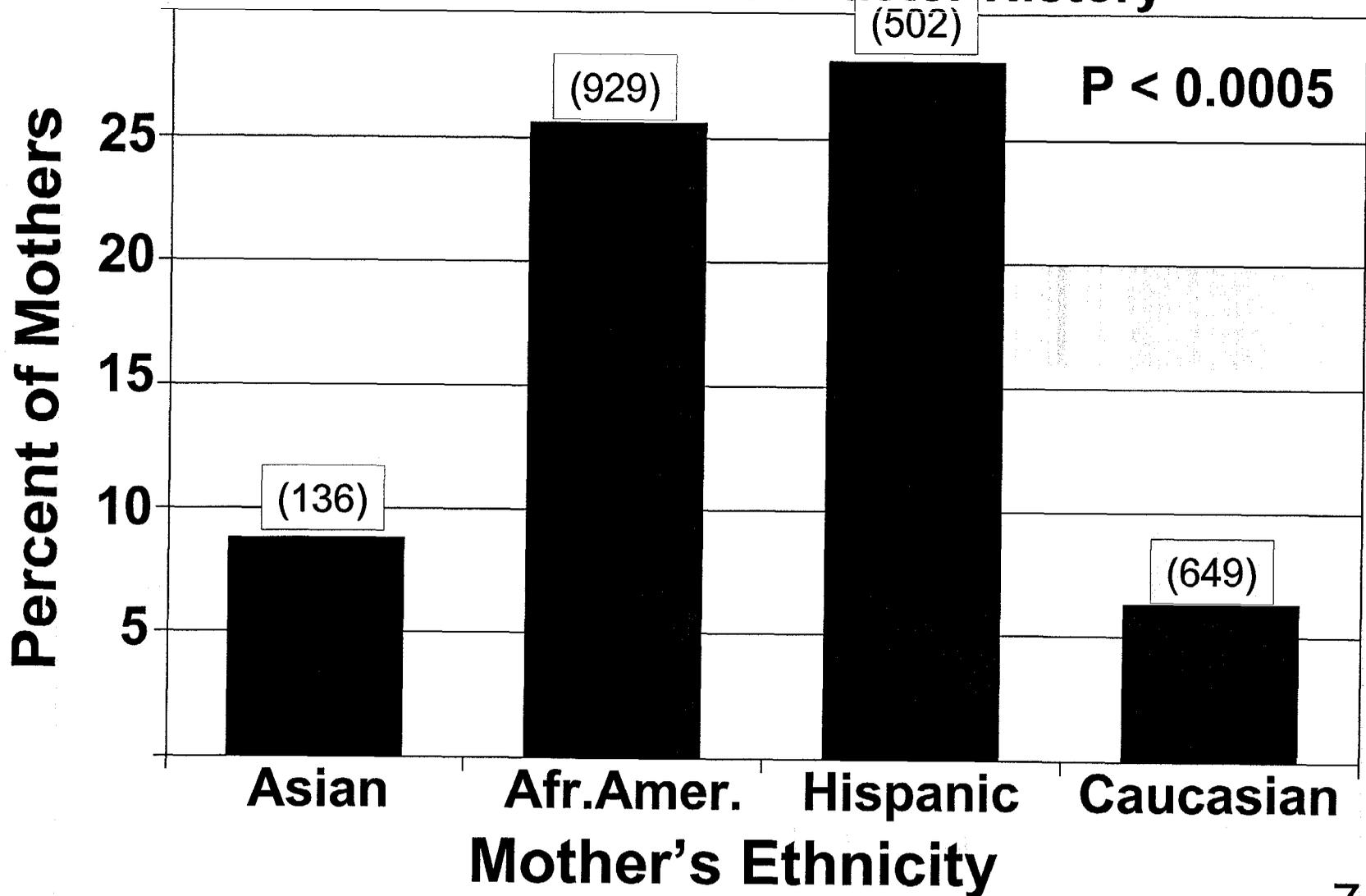
< 40 ml since 8/93

< 50 ml since 1/00

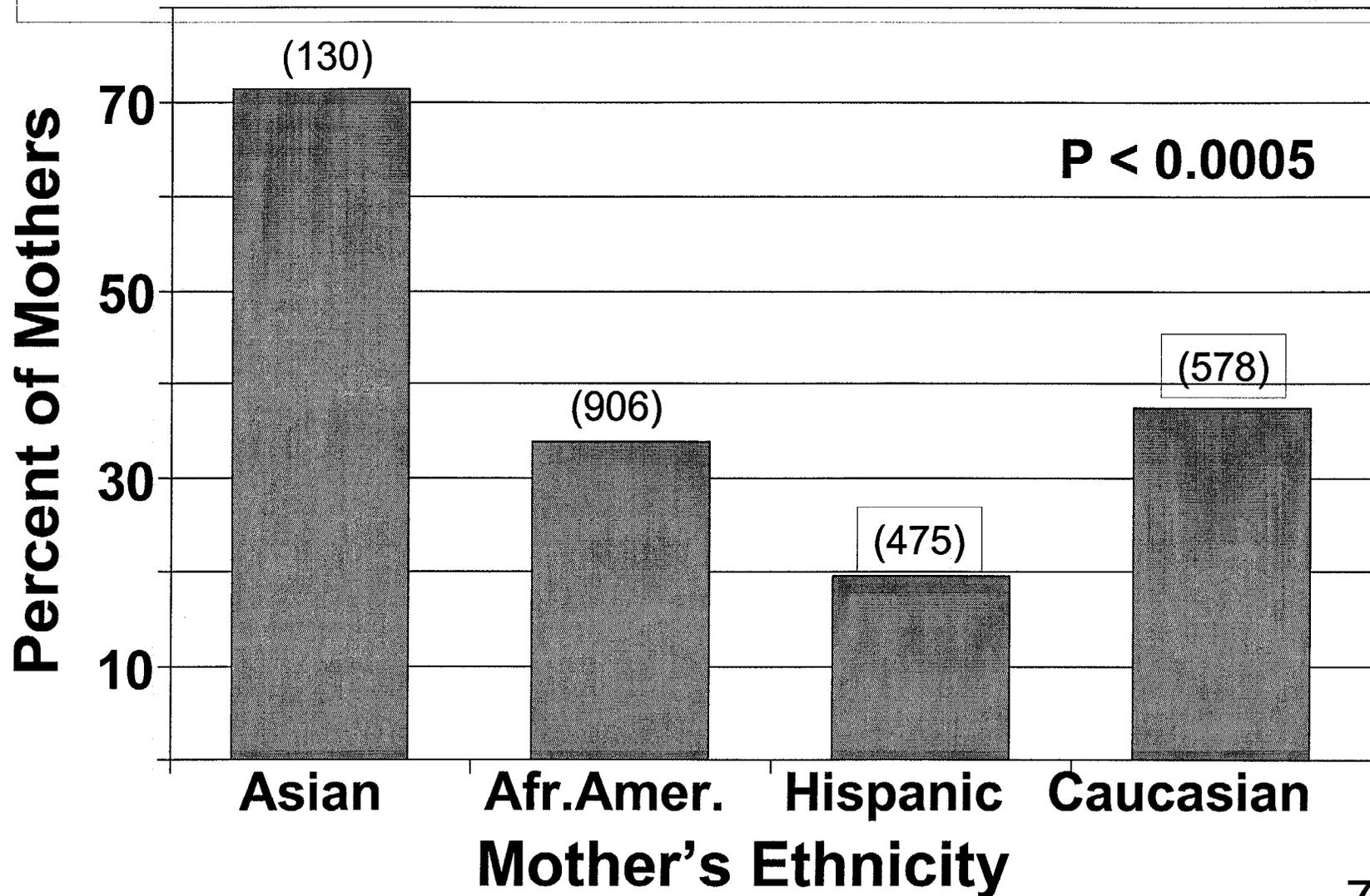
Any Blood or STD Risk Factor History



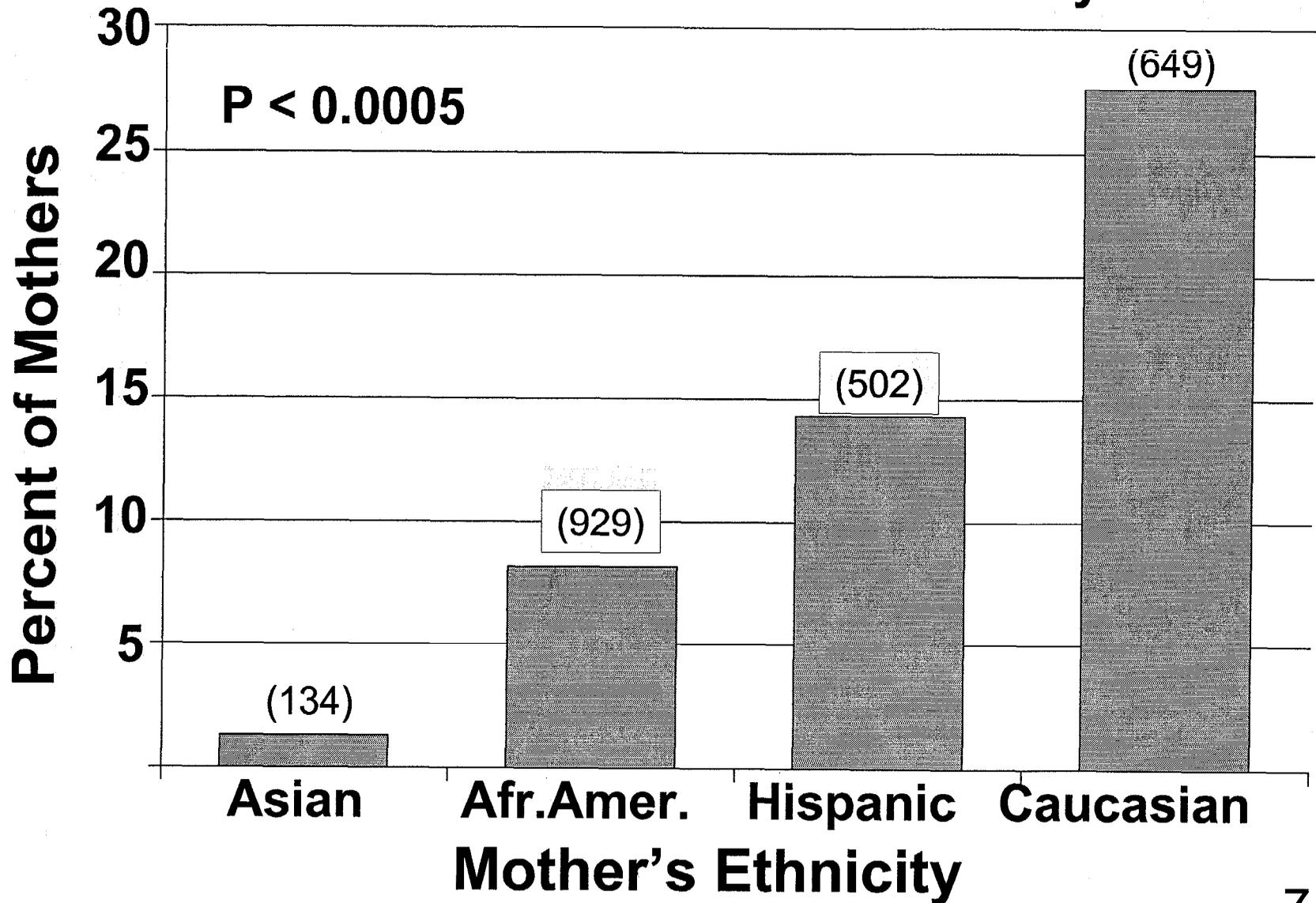
**Blood or Component Transfusion, Tattoo or
Body Piercing History in Mothers with a
Blood/STD Risk Factor History**



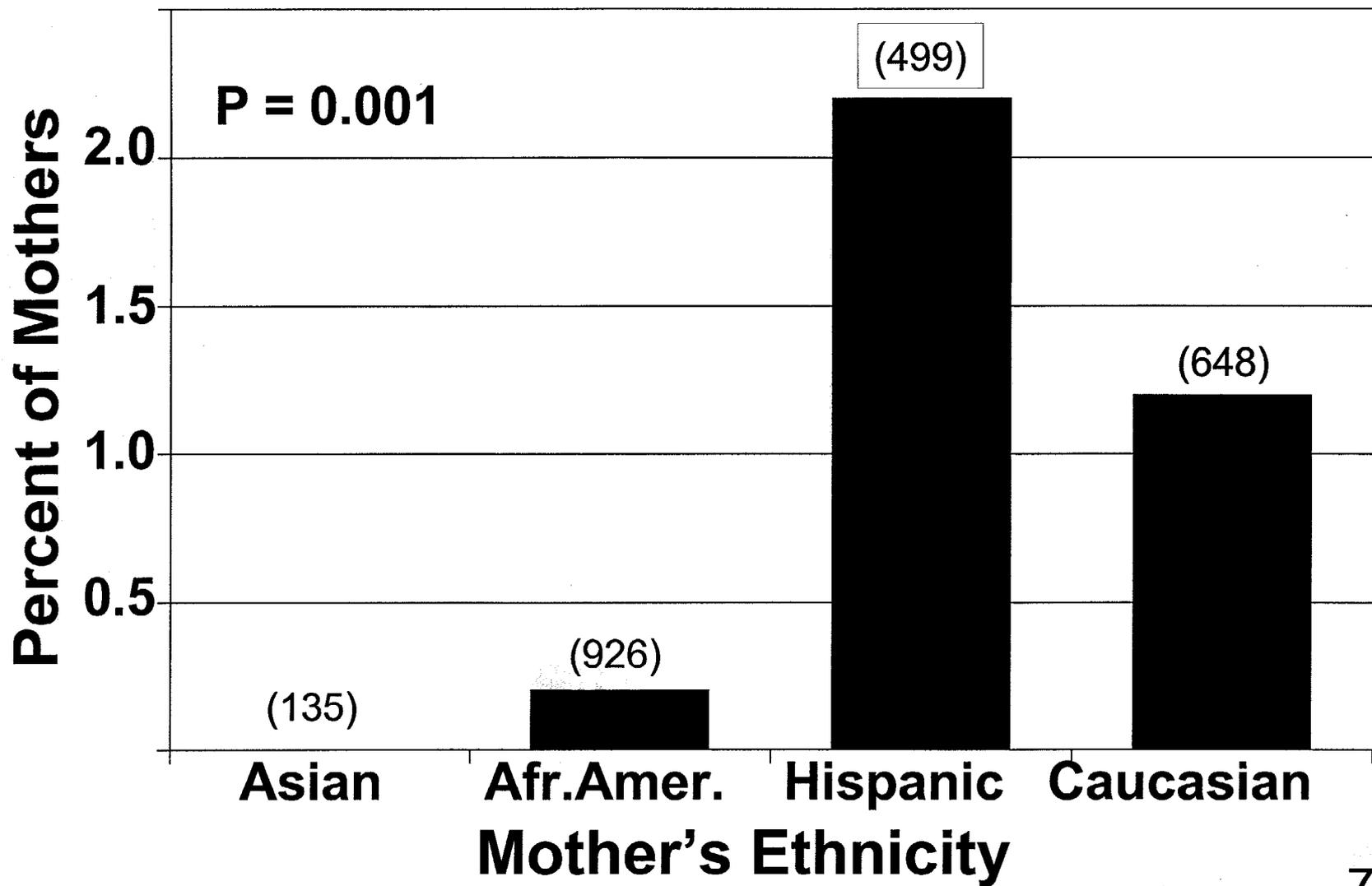
Contact with Blood or Body Fluids in Mothers with History with a Blood/STD Risk Factor History



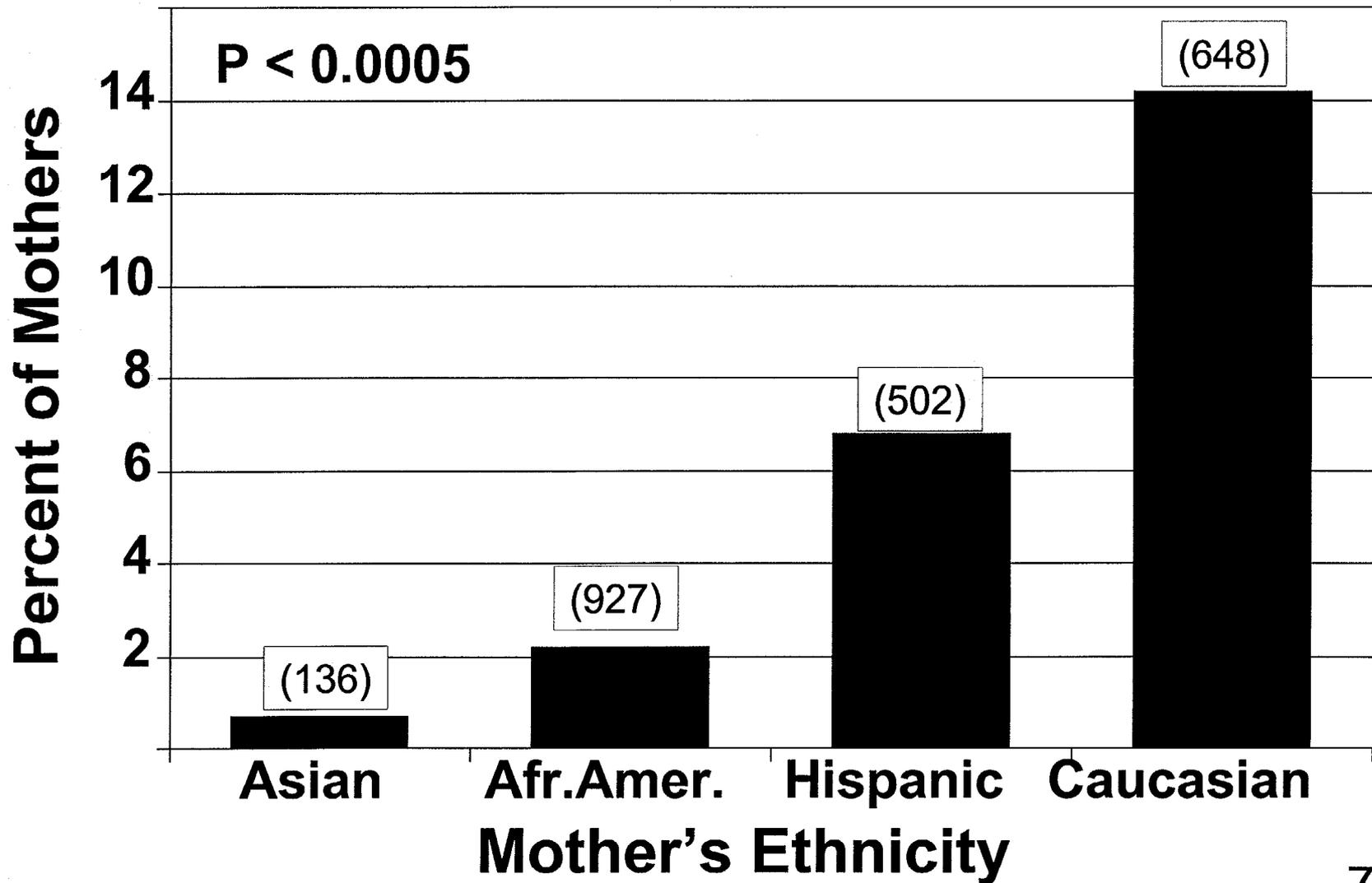
Hepatitis History in Mothers with a Blood/STD Risk Factor History



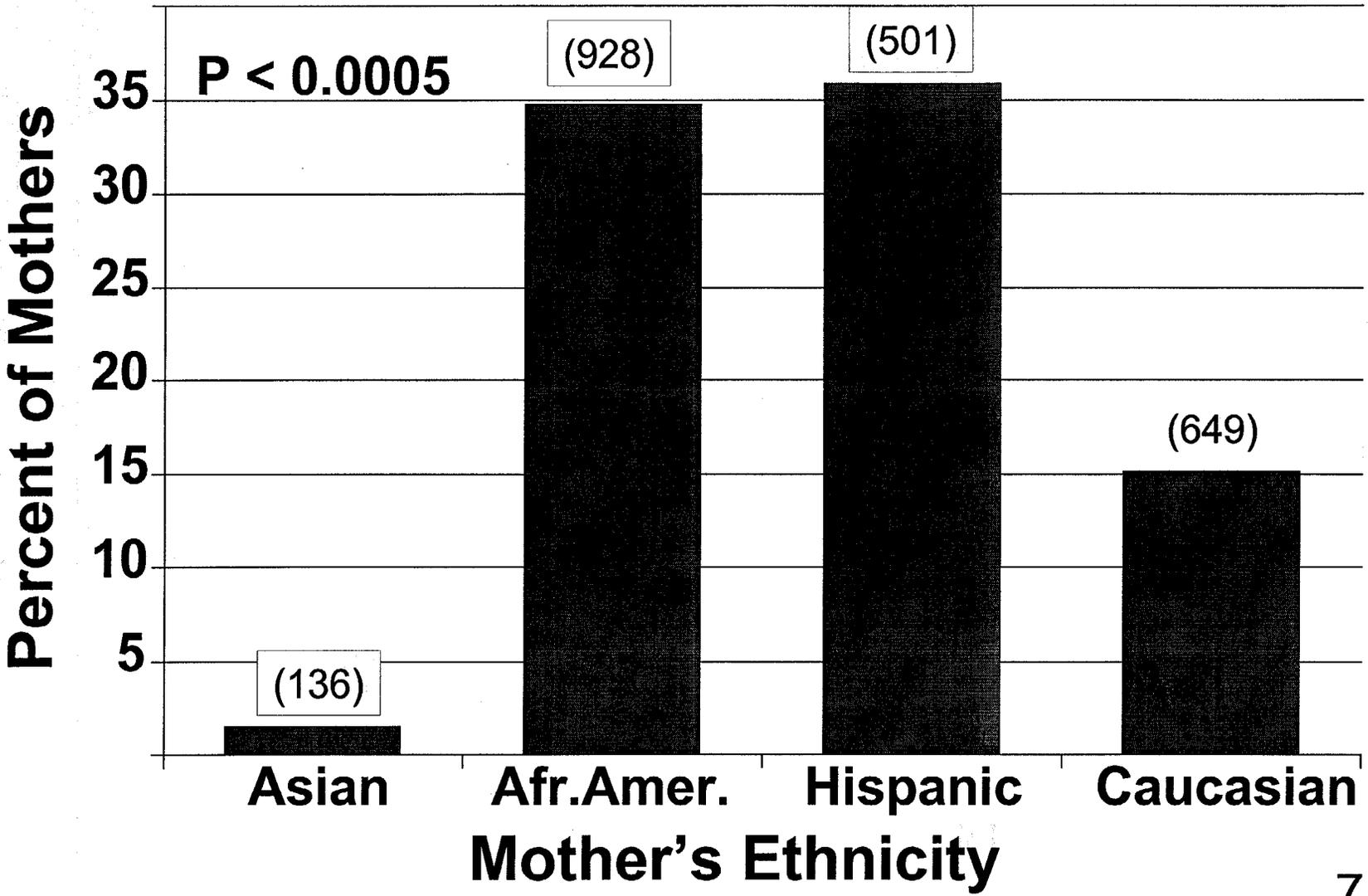
Injection Drug Use in Mothers with a Blood/STD Risk Factor History



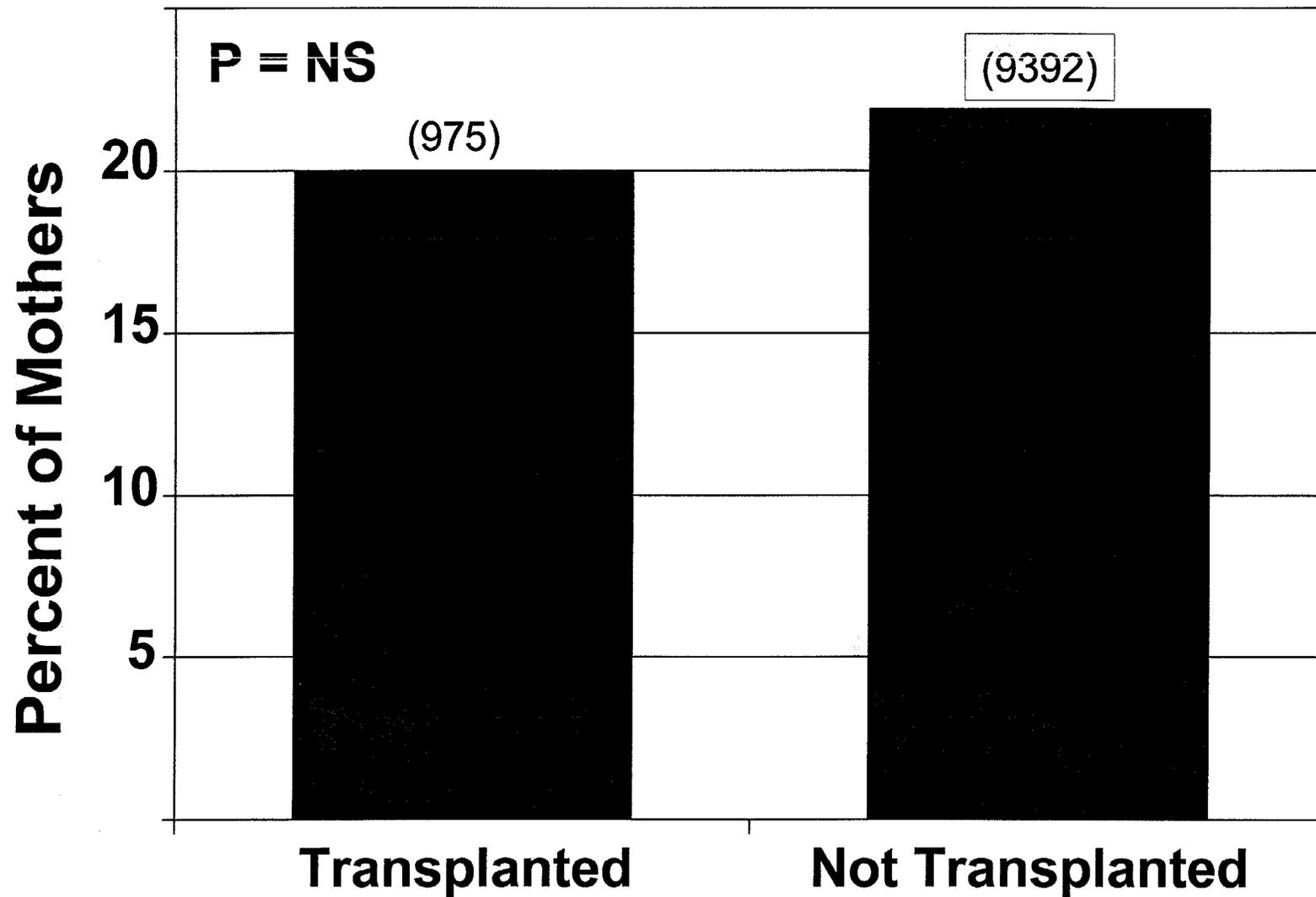
Sex with IDU in Mothers with a Blood/STD Risk Factor History



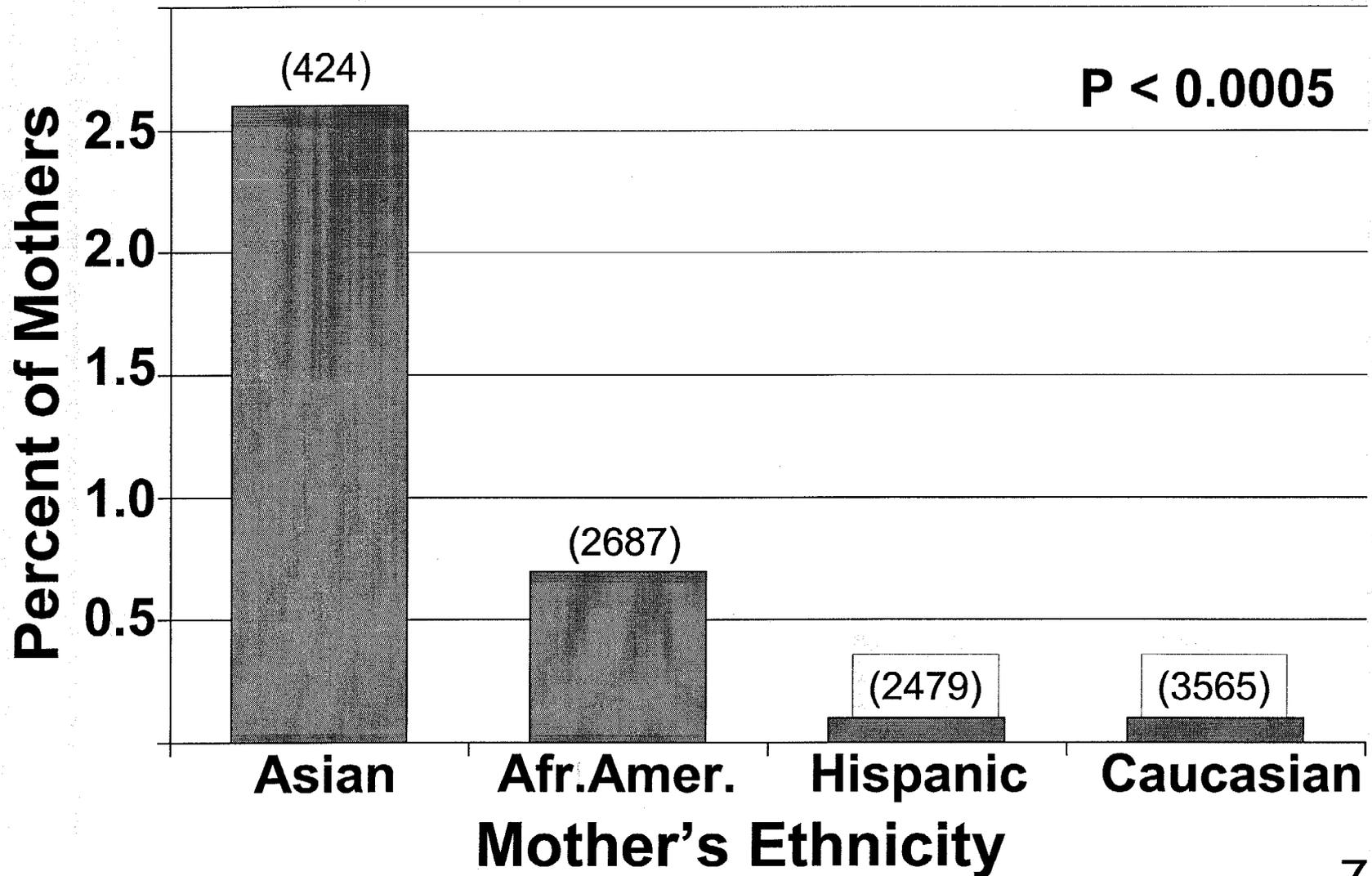
STD History in Mothers with a Blood/STD Risk Factor History



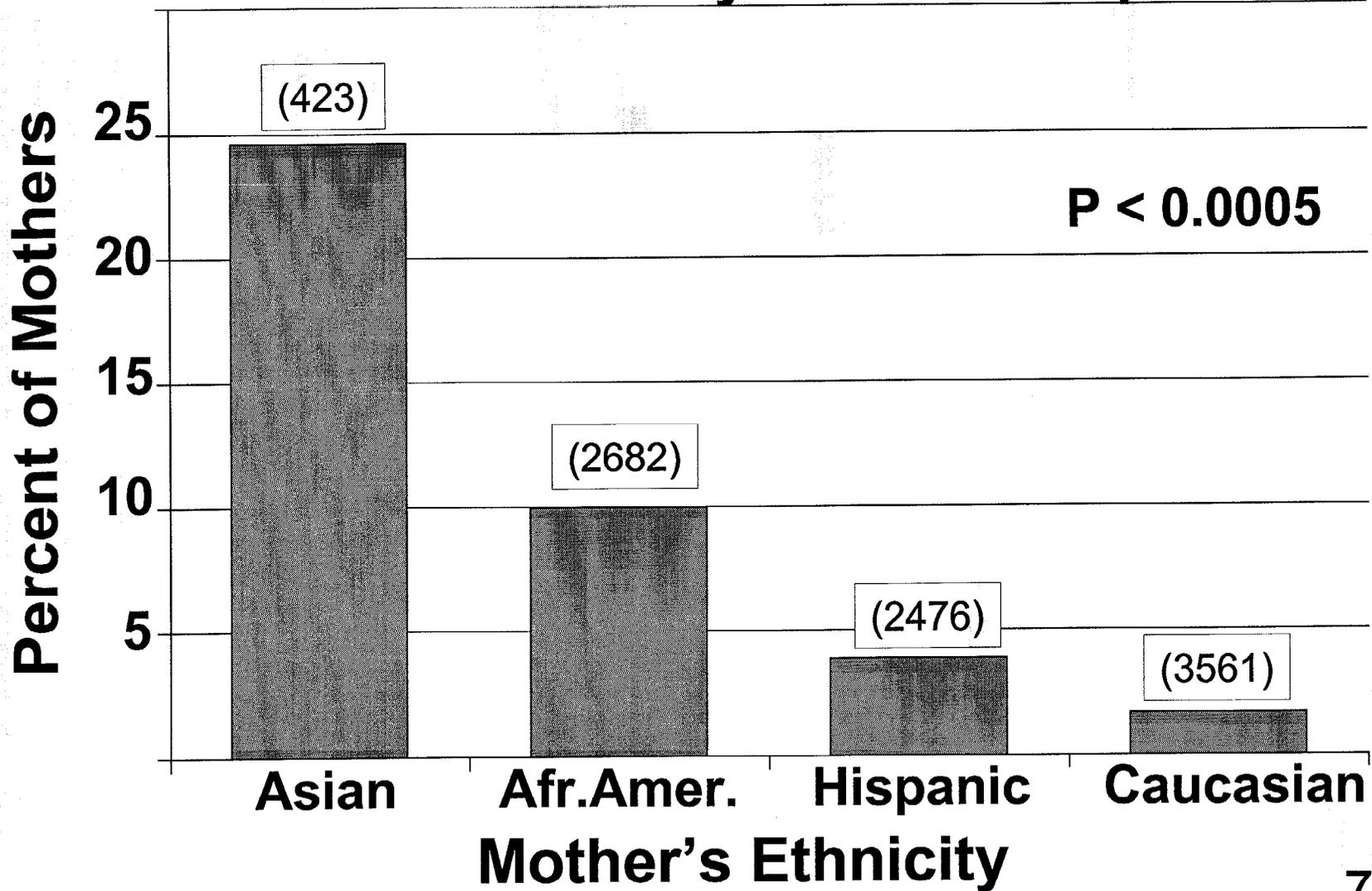
Any Blood or STD Risk Factor History

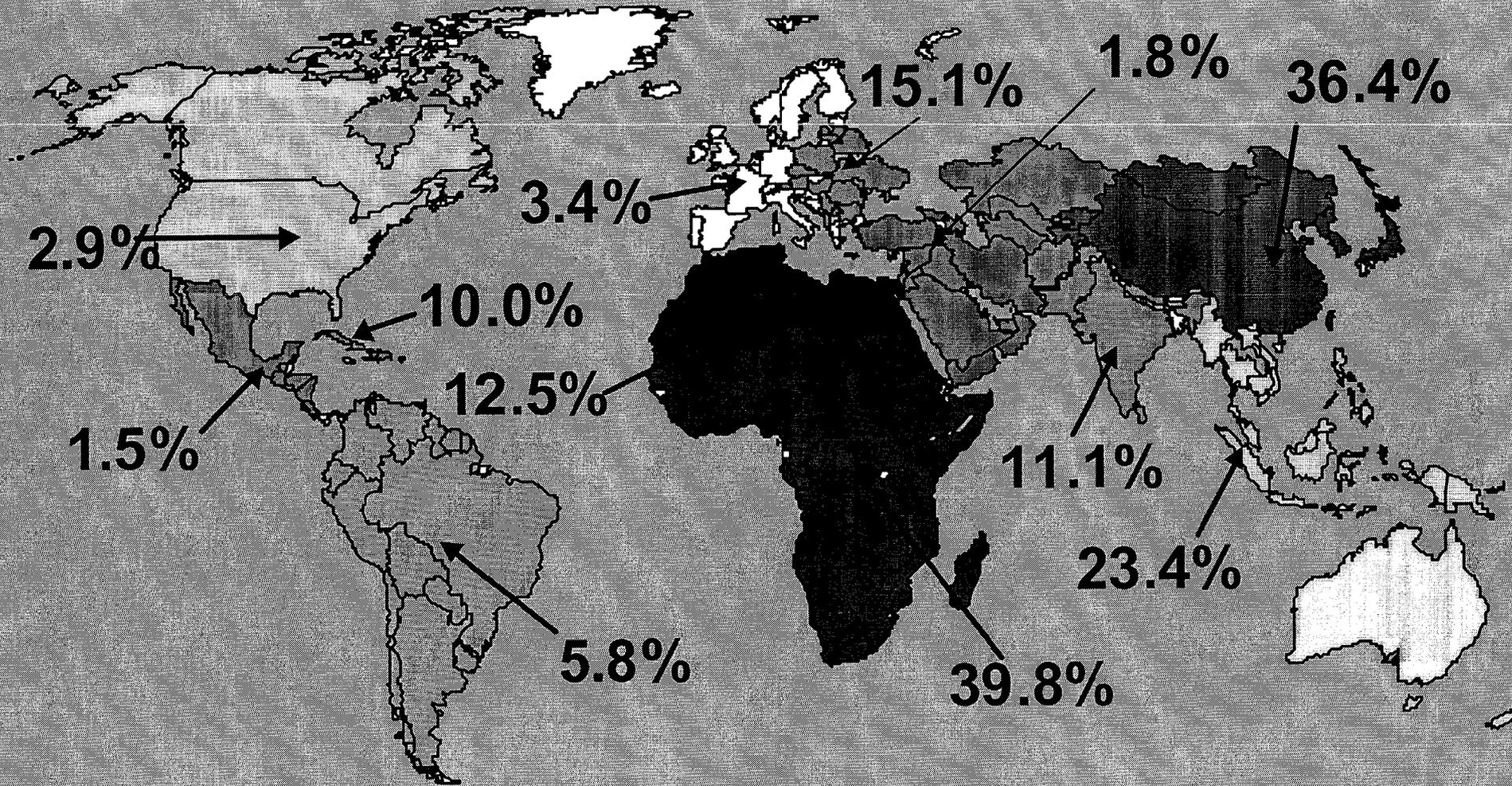


HBsAg Prevalence in Mothers by Ethnic Group



Anti-HBc Repeat Reactivity in Mothers by Ethnic Group

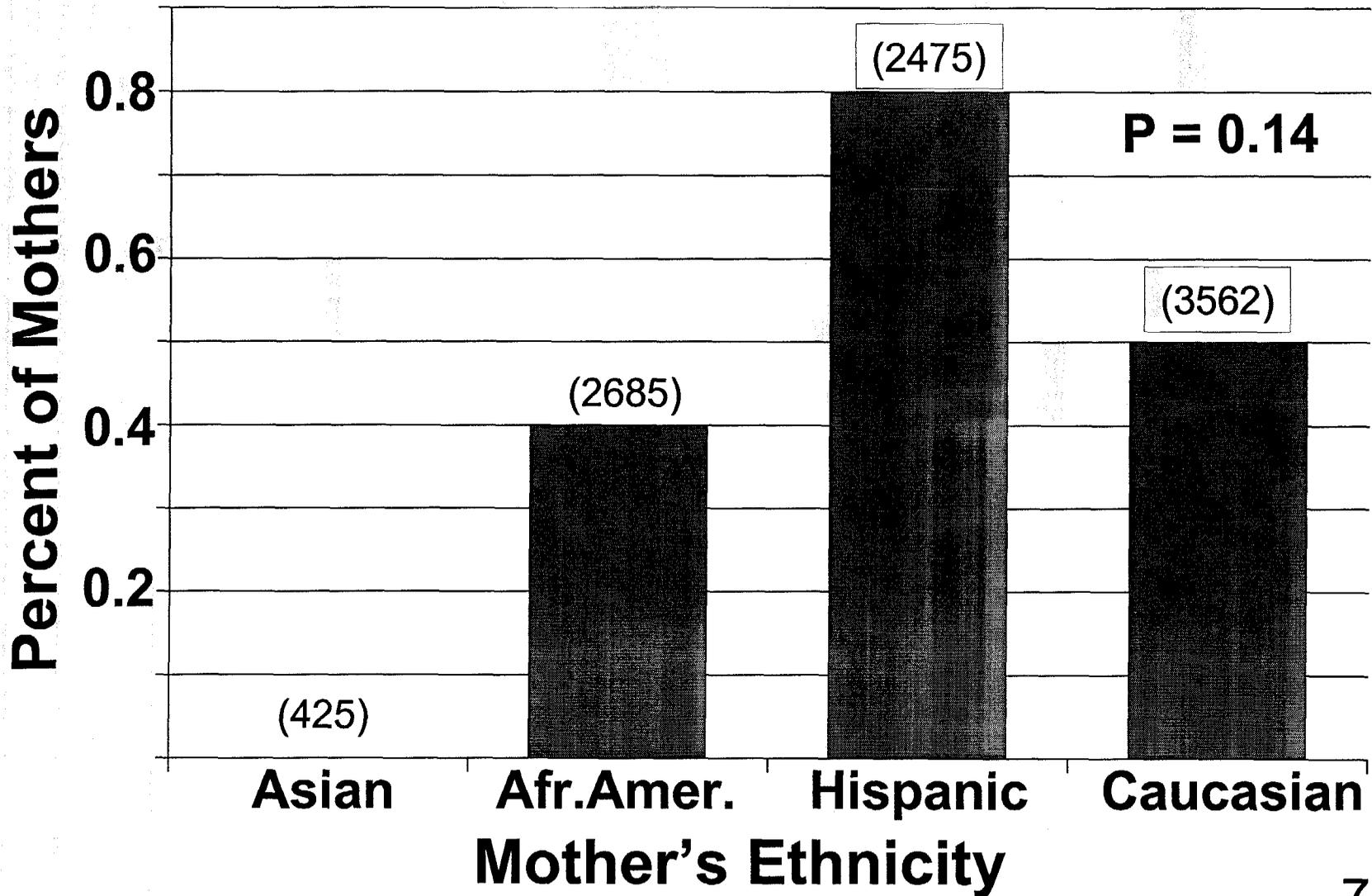




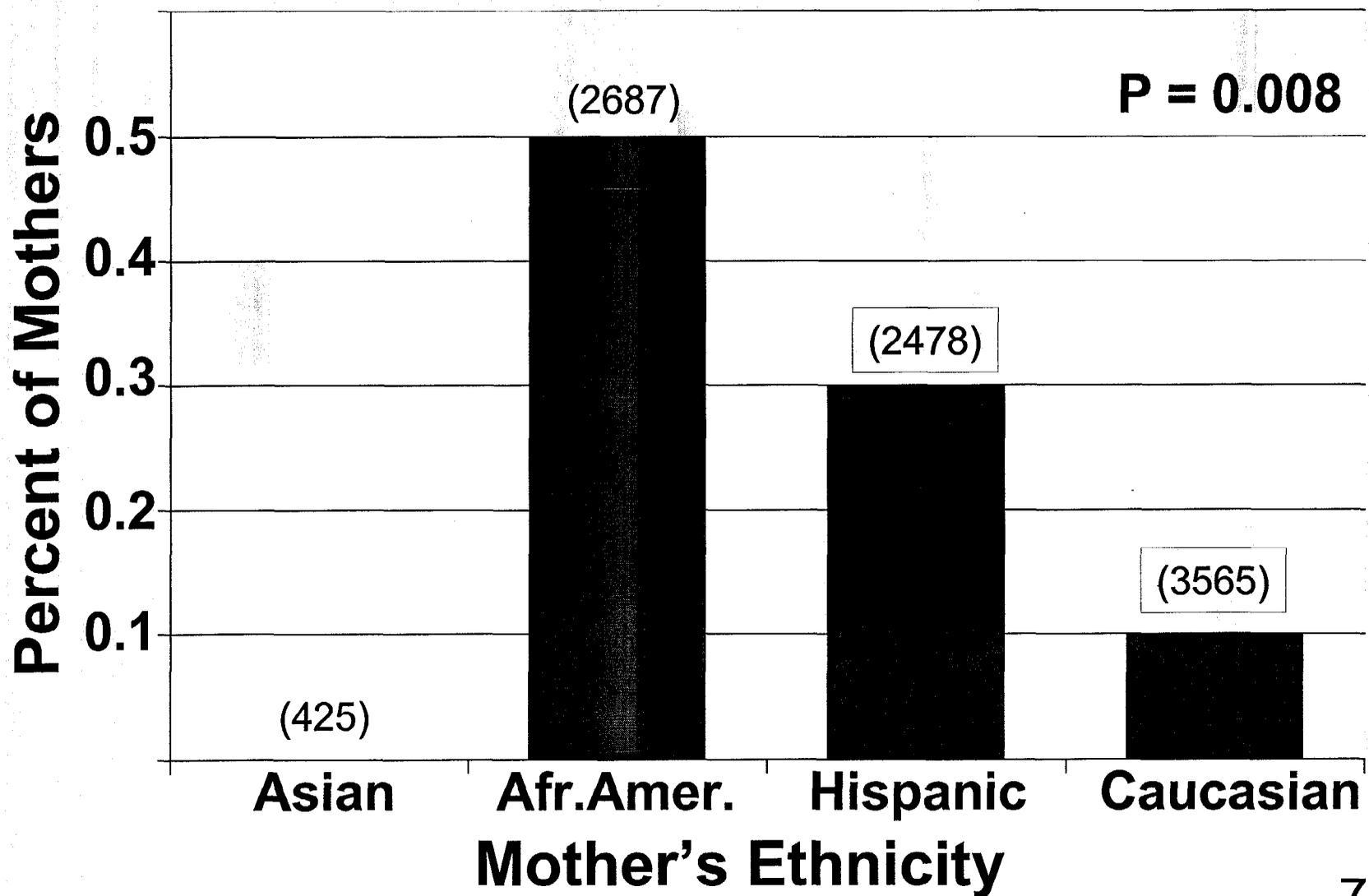
Anti-HBc Prevalence by Mother's Birthplace

(8/93 - 3/00)

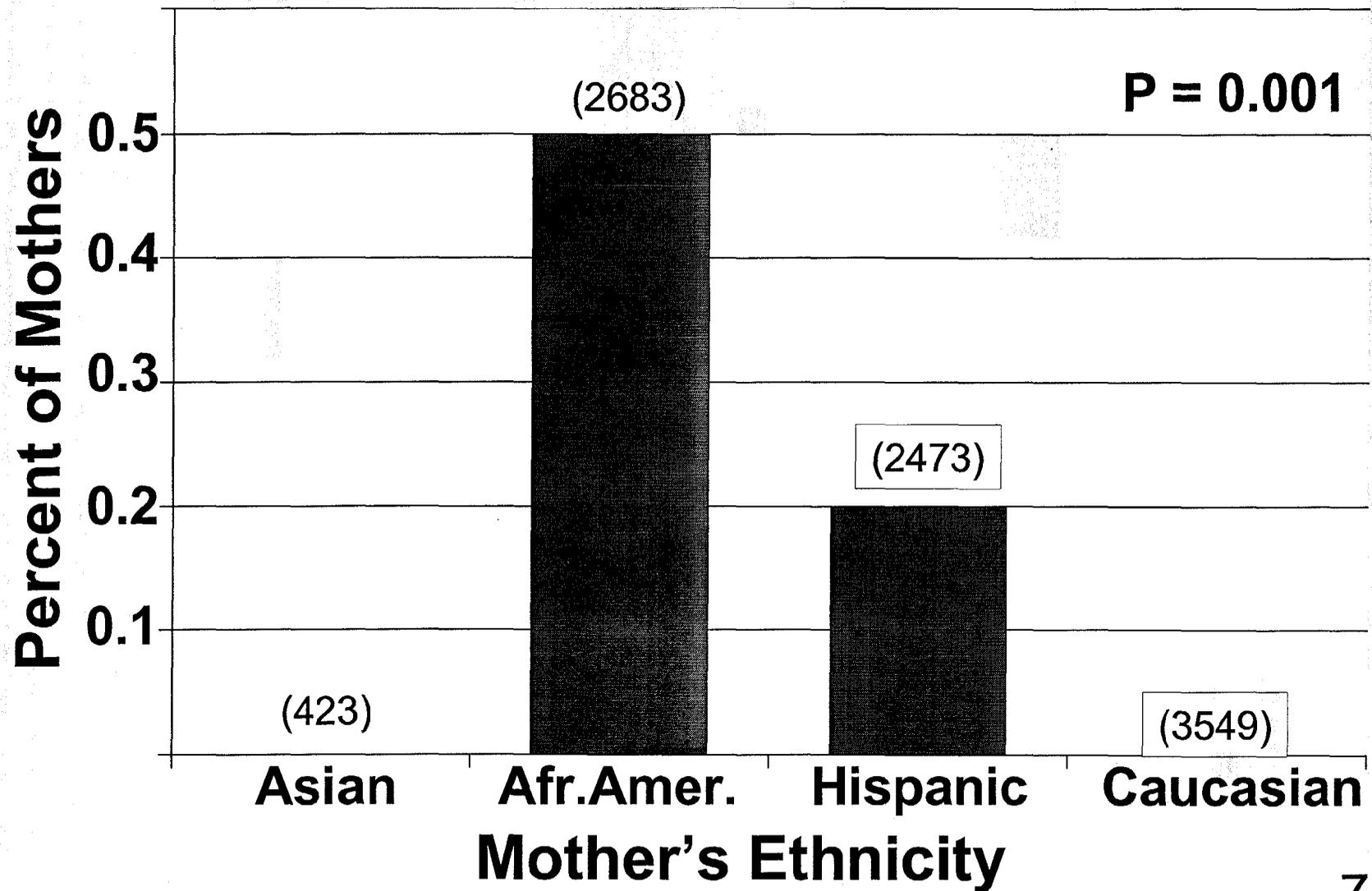
Anti-HCV Prevalence in Mothers by Ethnic Group



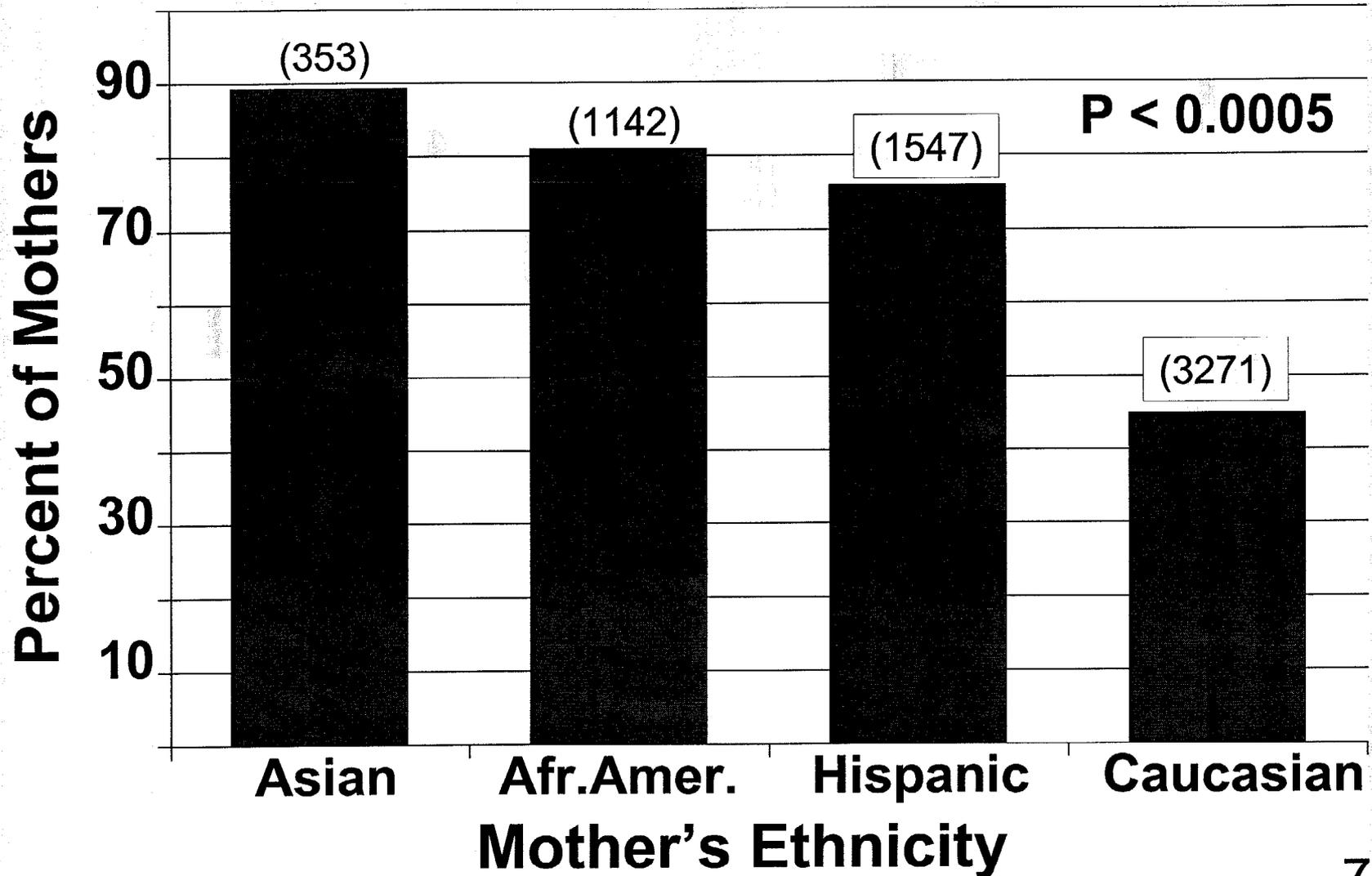
Anti-HIV Prevalence in Mothers by Ethnic Group



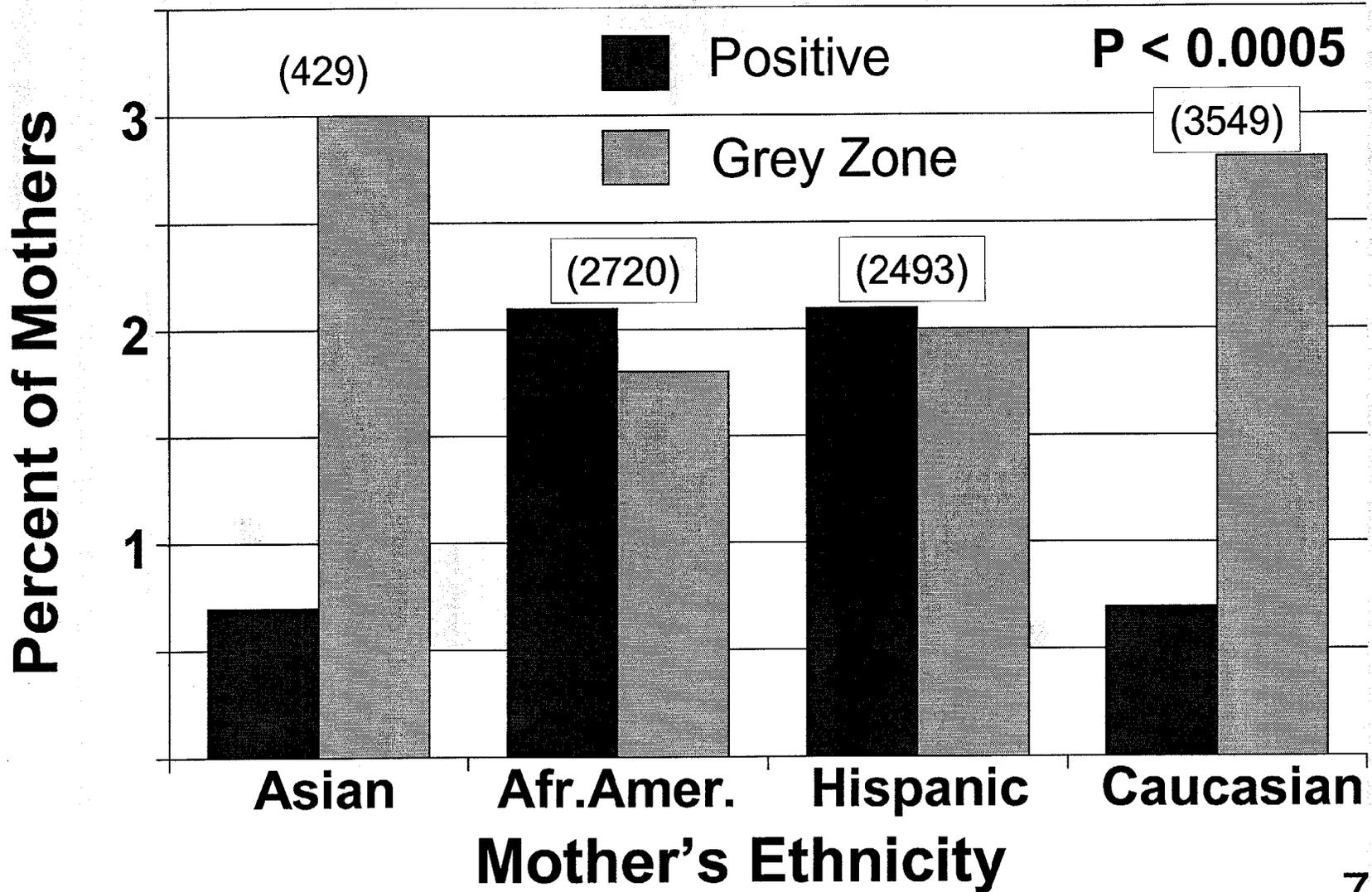
Anti-HTLV Prevalence in Mothers by Ethnic Group



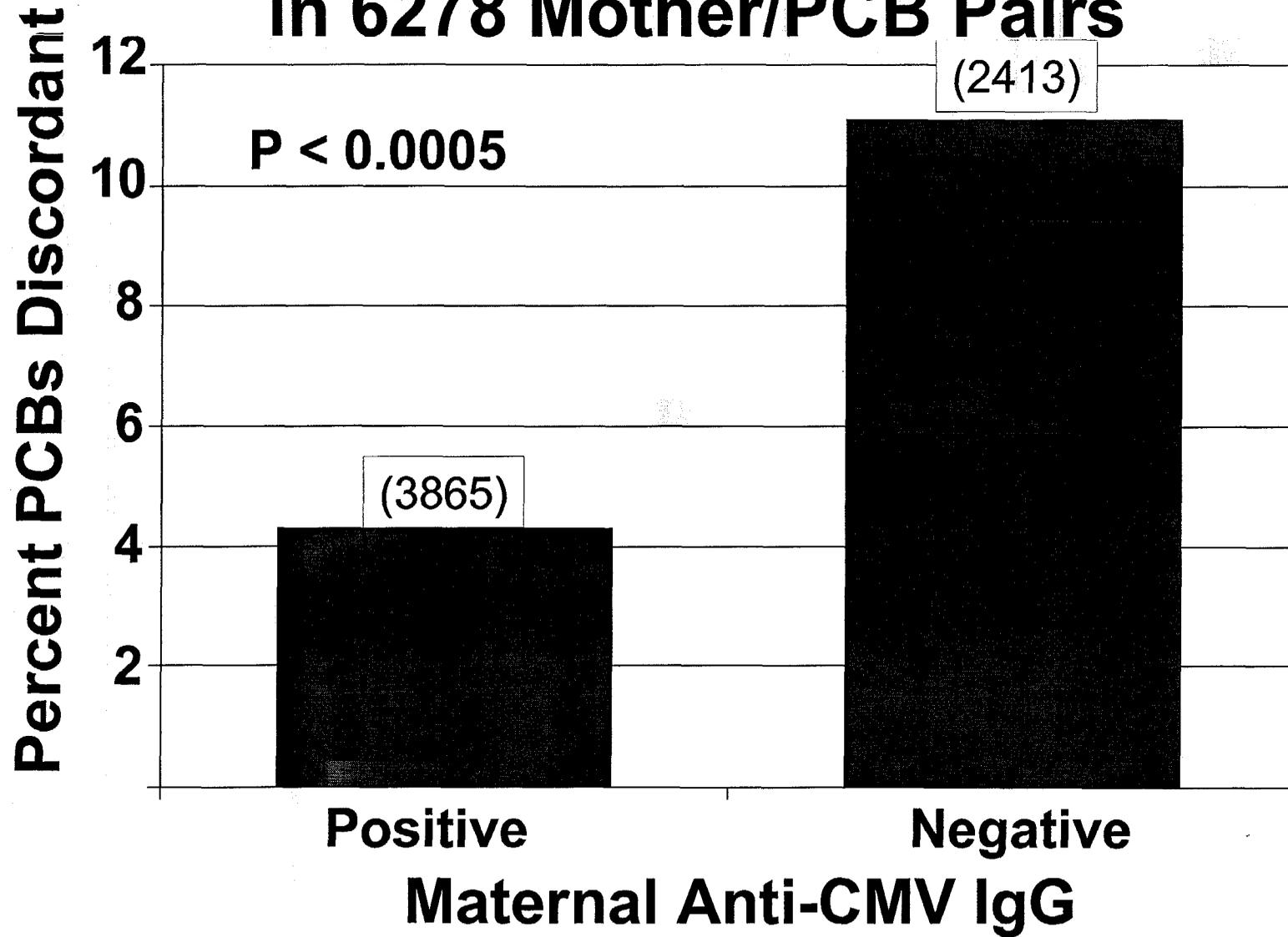
Anti-CMV IgG in Mothers by Ethnic Group



Anti-CMV IgM in Mothers by Ethnic Group



Discordant Anti-CMV IgG in 6278 Mother/PCB Pairs



Anti-HBc Prevalence by History of Blood or STD Risk Factor

Blood/STD Risk Factor	No. Tested	% Anti-HBc Positive
None	7221	4.6
Any	2007	9.7

$P < 0.0005$

HBsAg Prevalence by History of Blood or STD Risk Factor

Blood/STD Risk Factor	No. Tested	% HBsAg Positive
None	7231	0.1
Any	2010	1.5

$P < 0.0005$

Anti-HCV Prevalence by History of Blood or STD Risk Factor

Blood/STD Risk Factor	No. Tested	% Anti-HCV Positive
None	7225	0.4
Any	2008	1.0

P = 0.007

Anti-HIV Prevalence by History of Blood or STD Risk Factor

Blood/STD Risk Factor	No. Tested	% Anti-HIV Positive
None	7229	0.2
Any	2012	0.6

P = 0.001

Anti-HTLV Prevalence by History of Blood or STD Risk Factor

Blood/STD Risk Factor	No. Tested	% Anti-HTLV Positive
None	7209	0.2
Any	2005	0.3

P = 0.8

Prevalence of Anti-HCV Repeat Reactive/RIBA-3 Negative by Blood and/or STD Risk Factor History

Blood/STD Risk Factor	No. Tested	% Anti-HCV Repeat Reactive
None	7225	0.1
Any	2008	0.1

P = NS

Prevalence of Anti-HIV Repeat Reactive/WB Negative by Blood and/or STD Risk Factor History

Blood/STD Risk Factor	No. Tested	% Anti-HIV Repeat Reactive
None	7228	0.4
Any	2013	0.3

P = NS

Prevalence of Anti-HTLV Repeat Reactive/WB Negative by Blood and/or STD Risk Factor History

Blood/STD Risk Factor	No. Tested	% Anti-HIV Repeat Reactive
None	7207	1.2
Any	2005	0.8

P = NS

ID Label

NYBC PLACENTAL BLOOD PROGRAM DATA FORM

COLLECTION DATA

Date of Collection: _____ (mm/dd/yr) Time Collection Began: _____ (AM/PM)

No. of Infants Delivered in This Pregnancy: _____

If Multiple Birth, Is This Infant A, B or C?

If Multiple Birth, is the Placenta Single? Yes No

Placenta Weight (grams): _____

Number of Arteries: Two One

Number of Sticks for This Collection: _____

Collection Bag Lot Number: _____ Expiration Date: _____
(mm/yr)

Was extra anticoagulant added? Yes No

If Yes, what volume? _____ mL.

If Yes, Collection Bag Lot Number _____ Expiration Date: _____
(mm/yr)

Collection by: _____ (Initials), _____ (Staff ID Number)

Note: Complete Rest of Data Form Only If Mother Gives Consent.

LABOR AND DELIVERY

ID Label

Mother's Age (years): _____

Date of Infant's Delivery: _____ (mm/dd/yr) Time of Infant's Delivery: _____ (AM/PM)

Did Mother Have Labor? Yes No

If Yes, Length of Labor: _____ in hours (if < 1 hour, _____ minutes).

If Yes, Was Labor... Induced, or Augmented with Drugs? Neither

Type of Anesthesia: General Spinal Epidural Local/Pudendal IV/PO Meds Only
 Other: _____ None
(specify)

Route of Delivery: Vaginal C-Section

If Vaginal, Was Delivery By ... Forceps, Vacuum Extracted or Assisted Neither?

If C-Section, What Was The Reason? Sched./Elective Failed VBAC Other _____
(specify)

Ruptured Membranes Before Delivery? Yes No

If Yes, Type of Rupture: Spontaneous AROM

If Yes, Duration of Rupture: _____ in hours (if < 1 hour, _____ minutes).

Was Meconium Passed
or Were
Membranes Stained?
 Yes No

Genital Infection or Sores in Mother at Delivery? Yes No

If Yes, What Was the Diagnosis? _____

Fever ($\geq 100^{\circ}$ C) During Labor? Yes No

If Yes, Mother's Highest Temperature Prior to Delivery: _____ $^{\circ}$ C (_____ $^{\circ}$ F)

If Yes, What Was the Diagnosis? _____

Was Chorioamnionitis (Amnionitis) Diagnosed? Yes No

Other Complications During Labor and Delivery? Yes No

If Other Complications, What Diagnosis? _____

Antibiotics Taken Before Delivery (within 24 hours)? Yes No

If Yes, Name of Drug(s): _____

Other Medications Taken Before Delivery (within 24 hours)? Yes No

If Yes, Name of Drug(s): _____

Mother's Parity: No. of Pregnancies (Including Current): _____ No. of Live Births (Including Current): _____

No. of Miscarriages/Ect.Preg/Still Birth: _____ No. of Induced Abortions: _____

Medical Record Reviewed by: _____ (Initials), _____ (Staff ID Number)

INFANT'S DATA

Sex: Male Female Birth Weight (grams): _____

Fetal Distress? Yes No 5 minute Apgar: _____

Fetal Monitor? Scalp External Fetal Monitor None

Gestational Age (weeks) (Pediatrician's Examination): _____

Any Complications in Infant Before Discharge Home? Yes No

If Yes, Anemia or Other Blood Disease? Yes No

If Yes, Diagnosis: _____

Jaundice? Yes No

If Yes, Diagnosis: _____ Highest Bilirubin (Total) _____

Infection? Yes No

If Yes, Diagnosis and Organism: _____

Birth Defect? Yes No

If Yes, Diagnosis: _____

Other? Yes No

If Yes, Diagnosis: _____

Comments: _____

Infant's Medical Record Reviewed by: _____ (Initials) _____ (Staff ID Numbers)

Saliva Specimen Collection: Age of Infant at Collection: _____ (in hours) Hours Since Last Feeding: _____

Saliva Collected/Supervised by: _____ (Initials) _____ (Staff ID Number)

MOTHER'S PRE-NATAL BLOOD TEST RESULTS

Was the Mother Tested During This Pregnancy for:

HBsAg? Yes No or No Record

If Yes, Negative or Positive? Most Recent Test Date: _____
(mm/dd/yr)

Anti-HIV? Yes No or No Record

If Yes, Negative or Positive? Most Recent Test Date: _____
(mm/dd/yr)

Syphilis? Yes No or No Record

If Yes, Negative or Positive? Most Recent Test Date: _____
(mm/dd/yr)

Mother's ABO Blood Group: _____ Mother's Rh Type: _____

Mother's Medical Record Reviewed by: _____ (Initials) _____ (Staff ID Number)

HISTORY OF THIS PREGNANCYPrenatal Care: Yes NoIf Yes, Care Given By: Private M.D. ClinicWas This Pregnancy a Result of Ovum Implantation or in vitro Fertilization? Yes NoIf Yes, Mother's Ovum? Another Woman's? If Another Woman's Ovum, was The Donor Related to the Birth Mother? Yes NoIf Related to the Birth Mother, What was the Relationship? _____If Yes, Spouse's Sperm? Another Man's? If Another Man's Sperm, was The Donor Related to the Birth Father? Yes NoIf Related to the Birth Father, What was the Relationship? _____Was This Pregnancy the Result of Artificial Insemination? Yes NoIf Yes, Spouse's Sperm? Another Man's? If Another Man's Sperm, was The Donor Related to the Birth Father? Yes NoIf Related to the Birth Father, What was the Relationship? _____

Estimated Date of Confinement (EDC): _____ (mm/dd/yr)

Fetal Diagnostic Tests: None Amniocentesis Chorionic Villous BiopsyIf Tested, Reason Done: Mother's Age Other Reason _____
(specify reason)If Tested, Was the Result ... Normal or Abnormal?If Abnormal, Give Diagnosis: _____Any Febrile Illness or Diagnosed Infections? Yes NoIf Yes, Diagnosis: _____ Onset Date _____ Rx: Yes No
(mm/dd/yr)Diagnosis: _____ Onset Date _____ Rx: Yes No
(mm/dd/yr)During This Pregnancy, Did the Mother Have Pre-Eclampsia? Yes No

During This Pregnancy, Did the Mother Have Any Other Type of Hypertension (not pre-eclampsia)?

 Yes NoDuring This Pregnancy, Did the Mother Have Diabetes Mellitus? Yes NoIf Yes, What Type: Type I or Juvenile Diabetes (insulin dependent)
 Type II or Adult Onset Diabetes (not insulin dependent)
 Gestational (only present during pregnancy, whether or not with insulin Rx)No. of Blood Transfusions During L and D or Post-Partum, BEFORE Mother's Blood Taken: _____

Comments: _____

Interview/Medical Record Review by: _____ (Initials) _____ (Staff ID Number)

FAMILY HISTORY

ID Label

Has the Mother Donated to the Program Before? Yes No Not Sure or Delivered in Program Period
 If Yes or Not Sure, Dates of Previous Births: _____ (mm/dd/yr)

Baby's Siblings (Live Born): # Brothers: Full _____ Half _____ # Sisters: Full _____ Half _____

Baby's Mother's Siblings (Live Born): # Brothers: _____ # Sisters: _____

Baby's Father's Siblings (Live Born): # Brothers: _____ # Sisters: _____

Did Any Siblings, Aunts or Uncles Die Before 10 Years of Age (including stillbirth)? Yes No

If Yes, Relationship to Baby and Cause of Death: _____

If Yes, Relationship to Baby and Cause of Death: _____

Is the Mother Adopted? Yes No **Is the Father Adopted?** Yes No

Are the Baby's Mother and Father Related to Each Other by Blood? Yes No

If Yes, How Are They Related to Each Other? _____

Have the Mother, Father, Grand Parents or Any Siblings, Aunts, or Uncles Had Any of the Diseases Below That Run in the Family or Are Hereditary?

Cancer/Leukemia: Yes No **If Yes**, List Affected Family Members (by Relationship to Baby) and Type of Cancer.

Diabetes Mellitus: Yes No **If Yes**, List Affected Family Members (by Relationship to Baby) and if Type I/Juvenile (insulin-dependent) or Type II/Adult-onset (not insulin dependent).

Red Blood Cell Diseases (e.g., Sickle Cell Disease or Trait, Thalessemia (Cooley's), Fanconi's Anemia, G6PD or other red cell enzyme deficiency, Spherocytosis, Elliptocytosis, Prophyria or Diamond-Blackfan Syndrome).

Yes No **If Yes**, List Affected Family Members (by Relationship to Baby) and Disease.

White Blood Cell/Immune Deficiency Diseases (e.g., SCID, Chronic Granulomatous Disease, Wiskott-Aldrich Syndrome, Hypoglobulinemia, Nezelhof's Syndrome, ADA or PNP Deficiency, DiGeorge's Syndrome, Erythrophagocytosis, Histiocytosis, Kostmann's Disease, X-linked Lymphoproliferative Disease, Chediak-Higashi Syndrome, Neutrophil Receptor Deficiency).

Yes No **If Yes**, List Affected Family Members (by Relationship to Baby) and Disease.

ID Label

Platelet Diseases (e.g., Glanzmann's Disease, Hereditary Thrombocytopenia, Hereditary Telangiectasia, Alport's Disease, Platelet Storage Pool Disease, Bernard Soulier Syndrome, von Willebrand's Disease).

Yes No **If Yes**, List Affected Family Members (by Relationship to Baby) and Disease.

Metabolic/Storage Diseases or Osteopetrosis (e.g., Tay-Sachs, Ataxia-Telangiectasia, Gaucher's, Niemann-Pick Syndrome, Lesch-Nyhan Syndrome, Hurler's, Hunter's or San Filippo's Disease, Krabbe's Disease, Mucopolysaccharidosis, Adrenoleukodystrophies or **Osteopetrosis**):

Yes No **If Yes**, List Affected Family Members (by Relationship to Baby) and Disease.

Other Diseases That Run in the Family:

Yes No **If Yes**, List Affected Family Members (by Relationship to Baby) and Disease.

INFANT'S ETHNIC BACKGROUND

MOTHER:

Mother's Race: (Mother's choice)

- Hispanic
- Black, non-Hispanic
- White, non-Hispanic
- Asian
- Other: _____ (specify)

Mother's Religious Background:

- Protestant
- Catholic
- Jewish
- Muslim
- Hindu
- Buddhist
- Other: _____ (specify)

Mother's Birthplace: _____ (Country)

If not USA/Canada, year immigrated: _____

Mother's Mother's Birthplace:

_____ (Country)

Mother's Father's Birthplace:

_____ (Country)

FATHER:

Father's Race: (Mother's choice)

- Hispanic
- Black, non-Hispanic
- White, non-Hispanic
- Asian
- Other: _____

Father's Religious Background:

- Protestant
- Catholic
- Jewish
- Muslim
- Hindu
- Buddhist
- Other: _____ (specify)

ID Label

Father's Birthplace: _____
(Country)

Father's Mother's Birthplace:

(Country)

Father's Father's Birthplace:

(Country)

Father's Ancestry (check all that apply):

<input type="checkbox"/> Western Europe	<input type="checkbox"/> China, Japan, Korea
<input type="checkbox"/> Eastern Europe	<input type="checkbox"/> Southeast Asia, Philippines
<input type="checkbox"/> Scandinavian Europe	<input type="checkbox"/> Pacific Islands (Melanesia/Polynesia)
<input type="checkbox"/> Mediterranean Europe	<input type="checkbox"/> India, Iran, Pakistan, Afghanistan
<input type="checkbox"/> Middle East	<input type="checkbox"/> N/S American Indian
<input type="checkbox"/> Africa	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Unknown/Uncertain (specify)	

MOTHER'S RISK FACTOR HISTORY

Did You Smoke During This Pregnancy? Yes No

In the Past Three Years, Have You Been Outside of U.S.A./Canada or Puerto Rico? Yes No

If Yes, What Country? _____ Most Recent Date: _____
(mm/dd/yr)

If Yes, What Country? _____ Most Recent Date: _____
(mm/dd/yr)

If Yes, What Country? _____ Most Recent Date: _____
(mm/dd/yr)

Since 1995, Have You Lived in England for Six Months or More? Yes No

If Yes, Date at Start of Residence: _____ (mm/dd/yr)

Date at End of Residence: _____ (mm/dd/yr)

Have You Ever had a Serious Illness? Yes No

If Yes, What Disease?: _____ Date of Onset: _____
(mm/dd/yr)

If Yes, What Disease?: _____ Date of Onset: _____
(mm/dd/yr)

If Cancer, Did You Take Any Cancer ChemoRx During This Pregnancy? Yes No

If Yes, Name of Drug (s): _____

Did You Take Tegesin During This Pregnancy? Yes No

Have You Ever had Malaria? Yes No

If Yes, Date of Most Recent Episode or Treatment: _____ (mm/dd/yr)

Have You **Ever** had Lyme Disease? Yes No
If **Yes**, Date of Most Recent Episode or Treatment: _____ (mm/dd/yr)

Have You **Ever** had Chagas Disease? Yes No
If **Yes**, Date of Most Recent Episode or Treatment: _____ (mm/dd/yr)

Have You **Ever** had Babesiosis? Yes No
If **Yes**, Date of Most Recent Episode or Treatment: _____ (mm/dd/yr)

Do You Have Creutzfeldt-Jakob Disease (CJD) or a Related Neurologic Illness? Yes No
If **Yes**, Name of Disease: _____

Has Anyone in Your Family Had Creutzfeldt-Jakob Disease (CJD) or a Related Illness?.... Yes No
If **Yes**, Name of Disease: _____ Who had It? _____

Have You **Ever** had Hepatitis, a Positive Test for Hepatitis or Hepatitis Virus Infection?... Yes No

If **Yes**, Type A? Yes No Date: _____
(mm/dd/yr)

Type B? Yes No Date: _____
(mm/dd/yr)

Type C? Yes No Date: _____
(mm/dd/yr)

Type D? Yes No Date: _____
(mm/dd/yr)

Type E? Yes No Date: _____
(mm/dd/yr)

Other/Unknown: Yes No Date: _____
(mm/dd/yr)

In the past 12 months, Have You Had Sex with, Lived with, or Had Any Other Type of Contact with a Person Who, During That Time, had Hepatitis, Jaundice, a Positive Test for Hepatitis or Hepatitis Virus Infection? Yes No

If **Yes**, Type of Hepatitis: _____ Date of Onset: _____ (mm/dd/yr)

Type of Contact: Sex Lived with (No Sex) Other: _____
Date of Most Recent Contact: _____ (mm/dd/yr) (specify)

If **Yes**, Type of Hepatitis: _____ Date of Onset: _____ (mm/dd/yr)

Type of Contact: Sex Lived with (No Sex) Other: _____
Date of Most Recent Contact: _____ (mm/dd/yr) (specify)

ID Label

During This Pregnancy, Did You Handle Dirty Cat Litter or Cat Feces?..... Yes No

If Yes, Did the Cat Ever Go Outdoors During the Pregnancy? Yes No

In the Past 12 Months, Have You Had Any Immunizations or Vaccinations?..... Yes No

If Yes, Product: _____ Most Recent Dose: _____ (mm/dd/yr)

If Yes, Product: _____ Most Recent Dose: _____ (mm/dd/yr)

In the Past 12 Months, Have You Had Acupuncture?..... Yes No

If Yes, Date of Most Recent Puncture _____ (mm/dd/yr)

In the Past 12 Months, Have You Had a Transfusion of Blood or Any Blood Cells or Component (including husband's WBCs for Rx of cardiolipin antibodies)?..... Yes No

If Yes, Type of Component (s) or Cells: _____

If Yes, Dates of Most Recent Transfusion: _____ (mm/dd/yr) _____ (mm/dd/yr)

In the Past 12 Months, Have You Had an Organ, Tissue, Cornea or Dura Mater Transplant? Yes No

If Yes, Date of Most Recent Transplant: _____ (mm/dd/yr)

In the Past 12 Months, Have You Gotten Ears, Nose or Any Other Body Part Pierced?..... Yes No

If Yes, Date of Most Recent Piercing: _____ (mm/dd/yr)

In the Past 12 Months, Have You Gotten Any Permanent Tattoos?..... Yes No

If Yes, Date of Most Recent Tattoo: _____ (mm/dd/yr)

Do You Have Hemophilia or Any Bleeding Disorder?..... Yes No

If Yes, Name of Disease: _____

If Yes, Have You Ever Been Treated with a Human-derived Clotting Factor? Yes No

..... If Yes, Date of Most Recent Treatment: _____ (mm/dd/yr)

Have You Ever Received Human Pituitary Growth Hormone?..... Yes No

If Yes, When Was the Last Time? _____ (mm/dd/yr)

In the Past 12 Months, Have You had Contact with Someone Else's Blood or Other Body Fluids or with Equipment that Might have had Someone Else's Blood or Other Body Fluids on It?..... Yes No

If **Yes**, Was the Contact... at Work (_____) at Home or Other Site?
(mom's occupation)

If **Yes**, Was There Any Specific Accidental Exposure? Yes No

If **Yes**, Was it by **Needle Stick/Puncture?** Yes No
Date of Most Recent Stick: _____ (mm/dd/yr)

Cut? Yes No
Date of Most Recent Cut: _____ (mm/dd/yr)

Splash in Eyes/Mouth? Yes No
Date of Most Recent Splash: _____ (mm/dd/yr)

Have You **Ever** had Sex with Anyone Who was HIV (AIDS Virus) Positive or had AIDS?.... Yes No

If **Yes**, Date of Last Sexual Contact: _____ (mm/dd/yr)

Have You **Ever** had Sex with a Man Who was Hemophiliac, Bisexual or Used I.V. drugs?.... Yes No

If **Yes**, Date of Last Sexual Contact: _____ (mm/dd/yr)

Have You **Ever** had Sex with a Man Who has Been in Prison or was Incarcerated? Yes No

If **Yes**, Date of Last Sexual Contact: _____ (mm/dd/yr)

Have You **Ever** been Given or Taken Money or Drugs in Exchange for Sex?..... Yes No

If **Yes**, When was the Last Time? _____ (mm/dd/yr)

In the Past 12 Months, Have You been Treated for or Diagnosed with a Sexually Transmitted Disease (STD)? Yes No

If **Yes**, What Was the STD? Syphilis Yes No Date of Most Recent Dx or Rx: _____ (mm/dd/yr)

Gonorrhea Yes No Date of Most Recent Dx or Rx: _____ (mm/dd/yr)

Genital Herpes Yes No **If Herpes, Date of First Episode.** _____ (mm/dd/yr)

Chlamydia Yes No Date of Most Recent Dx or Rx: _____ (mm/dd/yr)

Other STD Yes No Date of Most Recent Dx or Rx: _____ (mm/dd/yr)

If **Other STD**, Give Diagnosis: _____

Have You **Ever** Used Recreational Drugs with a Needle (Intravenous or Under the Skin)?..... Yes No

If **Yes**, Date Last Used: _____ (mm/dd/yr)

ID Label

Have You **Ever** Used Cocaine or Crack Cocaine? Yes No

If **Yes**, Date **Last** Used: _____ (mm/dd/yr)

Have You **Ever** Tested Positive for AIDS ("SIDA") or the Human Immunodeficiency Virus (HIV)? Yes No

In the Past 12 Months, Have You had Any AIDS-like Symptoms? Yes No

If **Yes**, Date of Onset of Symptoms: _____ (mm/dd/yr)

If **Yes**, which symptoms? (check all symptoms the mother had)

- Unexplained Persistent Fever or Cough
- Unexplained Weight Loss
- Night Sweats,
- Swollen Lymph Glands
- Purple Spots on Your Skin.

Are There Any Needle Tracks Suggesting Drug Abuse? Yes No Could Not Examine Well

Do You Think the History is Accurate? Yes No

If **No**, Why Not? (check all that apply)

- Comprehension
- Language Barrier
- Witnesses/Family Members in the Room
- Father's Family History Questionable
- Other (_____)
(specify)

Comments: _____

Interviewer/Examiner: _____ (Initials) _____ (Staff ID Number)

Note: To Protect Confidentiality, This Page Will Be Detach From Data Form One Month After Test Results are Reported.

Mother's Name: _____
(first) (m.i.) (last)

Address: _____

Home Telephone: _____

Mother's Chart Number: _____

Infant's Chart Number: _____

FedEx USA Airbill

FedEx Tracking Number

804118970996

Form I.D. No.

0200

Recipient's Copy

1 From [Redacted]

Date [Redacted]

Sender's Name PABLO RUBINSTEIN, MD Phone 212 570-3230

Company NEW YORK BLOOD CENTER

Address 310 E 67th St IMMUNOGENET. Dept./Floor/Suite/Room

City NEW YORK State NY ZIP 10021

2 Your Internal Billing Reference Information

3 To Recipient's Name DOCKETS MANAGEMENT BRANCH Phone 301 827-0309

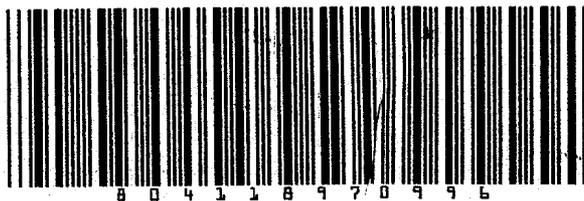
Company FOOD AND DRUG ADMINISTRATION

Address 5630 FISHER'S LAKE RY 1061 Check here if residence (Extra charge applies for FedEx Express Saver) Dept./Floor/Suite/Room

City ROCKVILLE State MD ZIP 20852

For HOLD at FedEx Location check here
 Hold Weekday (Not available with FedEx First Overnight)
 Hold Saturday (Not available at all locations) (Available for FedEx Priority Overnight and FedEx 2Day only)

For Saturday Delivery check here
 (Extra Charge. Not available to all locations) (Available for FedEx Priority Overnight and FedEx 2Day only)



4a Express Package Service Packages under 150 lbs. Delivery commitment may be later in some areas.

FedEx Priority Overnight (Next business morning) FedEx Standard Overnight (Next business afternoon)
 FedEx First Overnight (Earliest next business morning delivery to select locations) (Higher rates apply)
 FedEx 2Day (Second business day) FedEx Express Saver (Third business day)
FedEx Letter Rate not available. Minimum charge: One pound rate.

4b Express Freight Service Packages over 150 lbs. Delivery commitment may be later in some areas.

FedEx Overnight Freight (Next business day) FedEx 2Day Freight (Second business day) FedEx Express Saver Freight (Up to 3 business days)
(Call for delivery schedule. See back for detailed descriptions of freight services.)

5 Packaging FedEx Letter FedEx Pak FedEx Box FedEx Tube Other Pkg.
Declared value limit \$500

6 Special Handling (One box must be checked) (As per attached Shipper's Declaration) (Shipper's Declaration not required)

Does this shipment contain dangerous goods? No Yes Yes Declaration
 Dry Ice Dry Ice, 9, UN 1845 x kg. CA Cargo Aircraft Only
*Dangerous Goods cannot be shipped in FedEx packaging.

7 Payment Obtain Recipient FedEx Account No.

Bill to: Sender (Account no. in section 1 will be billed) Recipient Third Party Credit Card Cash/Check
(Enter FedEx account no. or Credit Card no. below)



Total Packages Total Weight Total Declared Value Total Charges
\$ 00

*When declaring a value higher than \$100 per shipment, you pay an additional charge. See SERVICE CONDITIONS, DECLARED VALUE, AND LIMIT OF LIABILITY section for further information. Credit Card Auth.

8 Release Signature

Your signature authorizes Federal Express to deliver this shipment without obtaining a signature and agrees to indemnify and hold harmless Federal Express from any resulting claims.

Questions?
Call 1-800-Go-FedEx (800)463-3339

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