OMB # 0925-0414 Exp: 4/06

- Affix label here-

Clinical Center/ID: __ __ __ __ - ___ ___ ___ - __

First Name _____M.I._____

Last Name _____

URINE COLLECTION

1. Date Collected: ☐☐-☐☐-☐☐ (M/D/Y)
2. Collected By: ☐☐☐ _____
3. Contact Type:
   - ☐ 1 Phone
   - ☐ 2 Mail
   - ☐ 3 Visit
   - ☐ 8 Other
4. Visit Type:
   - ☐ 1 Screening # ☐
   - ☐ 2 Semi-Annual # ☐☐
   - ☐ 3 Annual # ☐☐
   - ☐ 4 Non-Routine
5. Time Collected: ☐☐ : ☐☐ (Hr:Min) ☐ 1 AM ☐ 2 PM
6. WHI Urine Sample Number — -Affix Urine "Form" label here-

URINE PROCESSING

7. Processed by: ☐☐☐ _____
8. Time began centrifugation: ☐☐ : ☐☐ (Hr:Min) ☐ 1 AM ☐ 2 PM
9. Time sample placed in cryovial: ☐☐ : ☐☐ (Hr:Min) ☐ 1 AM ☐ 2 PM
10. Time cryovials placed in freezer: ☐☐ : ☐☐ (Hr:Min) ☐ 1 AM ☐ 2 PM
11. Aliquots:

Sample Size	Aliquot Color	11.1. Cryovial Number	11.2. Mark if urine placed in cryovial
1.8 ml	green	17	☐ 1
1.8 ml	green	18	☐ 1
1.8 ml	green	19	☐ 1

K _____