
**Investigator Registration Form**

**FACSIMILE TRANSMITTALz**

| | |
|---|---|
| **To:** | **From:** |
| **Fax:** | **Date:** |
| **Tel:** | **Pages: 4** |
| **Re: Investigator Questionnaire** | **Cc:** |

**Dear Sir/Madam:**

**Thank you for your interest in iProcess Investigator Match. Please complete and fax the accompanying questionnaire to iProcess at (714) 242-9973, to the attention of Investigator Registration.**

**Again, thank you for your interest.**

**iProcess Investigator Match**
**6846 Glen Cove**
**Mason,OH 45040**
**Tel: (714) 396 1195**
**Fax: (714) 242 - 9973**

## I. BACKGROUND INFORMATION

| *Last Name: | *First Name: | M.I. | *Degree1: | Degree2: | Professional Certification(s): |
|---|---|---|---|---|---|
| *Specialty 1: ☐ Board Certified ☐ Board Eligible | | | Specialty 2: ☐ Board Certified ☐ Board Eligible | | |
| Email address: | | | | | |

## II. PRIMARY CONTACT FOR UPCOMING TRIAL

| *Last Name: | | *First Name: | |
|---|---|---|---|
| *Address 1: | | Address 2: | |
| *City: | | *State: | *Zip/Postal Code: |
| *Phone: | Ext: | Fax: | E-mail: |

### III. PRIMARY RESEARCH FACILITY

| *Facility Name: | | | |
|---|---|---|---|
| Primary Contact Last Name: | | Primary Contact First Name: | |
| *Street Address: | | | Suite/Floor/Room: |
| *City: | | *State: | *Zip/Postal Code: |
| *Phone: | Ext: | Fax: | Email Address: |
| Setting: ☐ Inpatient ☐ Outpatient ☐ Both | | IRB Type: ☐ Local ☐ Central ☐ Both | |
| IRB Meeting Frequency: ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Other | | | |

*Required field

## IV. CLINICAL TRIAL EXPERIENCE

| *Indicate all phases of research in which the Investigator has participated: ☐ I ☐ II ☐ III ☐ IV ☐ None |
|---|

Please list all of your clinical trial experience, beginning with the most recent experience. Also include any trials that you are currently conducting. If you require additional space, please copy this page.

| *Start Date: MO/YR | Sponsor | Protocol Number | *Phase |
|---|---|---|---|
| *Indication | | Drug | Drug Class |
| Enrollment Commitment: # | Patients Enrolled: | Evaluable Patients: | |

| *Start Date: MO/YR | Sponsor | Protocol Number | *Phase |
|---|---|---|---|
| *Indication | | Drug | Drug Class |
| Enrollment Commitment: # | Patients Enrolled: | Evaluable Patients: | |

| *Start Date: MO/YR | Sponsor | Protocol Number | *Phase |
|---|---|---|---|
| *Indication | | Drug | Drug Class |
| Enrollment Commitment: # | Patients Enrolled: | Evaluable Patients: | |

## V. PRIMARY RESEARCH FACILITY STUDY STAFF

| Last Name: | | First Name: | |
|---|---|---|---|
| Title/Role:<br>☐ Sub Investigator ☐ Study Coordinator<br>☐ Medical Technician ☐ Research Pharmacist<br>☐ Contracts Administrator ☐ Regulatory<br>☐ Other | | ☐ Full Time<br>☐ Part Time | |
| Number of years in clinical research: _____ yrs | | Number of years with your Facility/Org: _____ | |
| Phone:<br>() | Extension: | Fax:<br>() | E-mail: |

*Required field

| | | | |
|---|---|---|---|
| **Last Name:** | | **First Name:** | |
| **Title/Role:**<br>☐ Sub Investigator ☐ Study Coordinator<br>☐ Medical Technician ☐ Research Pharmacist<br>☐ Contracts Administrator ☐ Regulatory<br>☐ Other | | ☐ Full Time<br>☐ Part Time | |
| **Number of years in clinical research: _____ yrs** | | **Number of years with your Facility/Org: _____** | |
| **Phone:**<br>() | **Extension:** | **Fax:**<br>() | **E-mail:** |

## OTHER RESEARCH FACILITIES

**(IF YOU REQUIRE ADDITIONAL SPACE, PLEASE COPY THIS SECTION.)**

| | | |
|---|---|---|
| **Facility Name:** | | |
| **Address:** | | **Suite/Floor/Room:** |
| **City:** | **State:** | **Zip/Postal Code:** |
| **Setting:**<br>☐ Inpatient ☐ Outpatient ☐ Both | **IRB Type:**<br>☐ Local ☐ Central ☐ Both | |

## VI. SITE MANAGEMENT ORGANIZATION

| | | | |
|---|---|---|---|
| **Are you affiliated with a Site Management Organization (SMO)?** ☐ **Yes** ☐ **No** | | ***Is this relationship:**<br>☐ **Exclusive** ☐ **Non-exclusive** | |
| ***SMO Name:** | | | |
| **SMO Primary Contact Name:**<br><br>☐ **If the contact information is the same as Section II, check here and proceed to Section IV.** | | | |
| ***SMO Address:SMO Suite/Floor/Room:** | | | |
| ***City:** | | ***State:** | ***Zip/Postal Code:** |
| ***Phone:** | **Ext:** | **Fax:** | **E-mail:** |

***Required field**

**By signing this document, you or your authorized representative give iProcess the right to receive data about you collected by Institutional Review Boards or other third parties who possess information of a similar type to that disclosed herein. This information will be placed along with information you have submitted into your profile and will be available for your review, and will be disclosed to users of service for the purpose of matching you with appropriate clinical trials.**

_____ _____

**Signature of PI (or authorized representative)** **Date**