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**Introduction**

You are listed as a provider of genetics services in the *NCI Cancer Genetics Services Directory* as part of the National Cancer Institute's Web site. Below is an electronic form that shows the information about you and your services currently listed in the *Directory*. Please review the information and update it by typing any changes directly into the boxes.

If you have any questions, please send an email to [GeneticsDirectory@cancer.gov](mailto:GeneticsDirectory@cancer.gov).

**1. Contact Information**

Please verify all contact information. This address is used to contact you for data verification purposes. It may be the same as one of the practice locations listed in the online directory (see *Practice Locations* immediately below).

<b>Last Name:</b>	<input type="text" value="Baggins"/>
<b>First Name:</b>	<input type="text" value="Frodo"/>
<b>Middle Initial(s):</b>	<input type="text" value="S."/>
<b>Suffix:</b>	<input type="text"/>
<b>Institution:</b>	<input type="text" value="Cancer Center of Middle-Earth"/>
<b>Contact Address:</b>	<input type="text" value="Middle-Earth Cancer Center&lt;br/&gt;1511 Gandalf Gate Rd&lt;br/&gt;Mordor, ME 13579"/>
<b>Telephone:</b>	<input type="text" value="123-456-7890"/>
<b>Fax:</b>	<input type="text" value="123-456-7899"/>
<b>* E-mail:</b>	<input type="text" value="John.Doe@middle.earth"/>
<b>Publish email address in directory?</b>	<input type="text" value="Yes"/>
<b>Web Address:</b>	<input type="text" value="www.middle.earth/ring/"/>

**2. Practice Locations**

Please verify the practice location(s) for consultations and patient referrals, and list additional locations (up to a maximum of four total locations).

Location 1

**Institution:**

**Contact Address:**

**\* Telephone:**

Location 2

**Institution:**

**Contact Address:**

**\* Telephone:**

**3. Type of Health Care Professional**

Please verify information on type of health care professional (check all that apply).

- Clinical Psychologist (Ph.D., Psy.D.)
- Clinical Social Worker (M.S.W., D.S.W.)
- Genetic Counselor (M.S., M.Sc., M.A., C.G.C.)
- Geneticist (Ph.D.)
- Nurse (R.N., B.S.N., M.S.N., M.S., M.A., Ph.D.)
- Physician (M.D., D.O., or foreign equivalent)
- Other

**4. Degree(s)**

Please verify academic degrees.

**5. Specialties and Certifications**

Please verify genetics and oncology specialties and board certifications.

Specialty	Board Certified	Board Eligible	Year Eligible
<input type="checkbox"/> Clinical Biochemical Genetics	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Clinical Cytogenetics	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Clinical Genetics	<input type="checkbox"/>	<input type="checkbox"/>	

<input type="checkbox"/> Clinical Molecular Genetics	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Genetic Counseling	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Gynecologic Oncology	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Hematology	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Medical Genetics	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Medical Oncology	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Molecular Genetic Pathology	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Oncology Nursing	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Pediatric Hematology-Oncology	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Radiation Oncology	<input type="checkbox"/>	<input type="checkbox"/>	

### 6. Team Services

Are you a member of an interdisciplinary team?

- Yes
- No

If so, please verify the services provided by you or members of your team (check all that apply).

- Appropriate pre- and post-test counseling and informed consent
- Follow-up plan of care
- Genetic susceptibility testing
- Patient cancer risk assessment
- Patient genetics education

### 7. Professional Services

Do you currently provide professional services?

- Yes
- No

Are you willing to accept calls or e-mails from individuals seeking familial cancer risk counseling and/or genetic susceptibility testing?

- Yes
- No

Please indicate if there are restrictions to services provided (e.g., a person must be eligible for a clinical trial in order to receive services).

- Yes (Please specify)

No

## 8. Predisposing Syndromes

Please verify the familial cancer predisposing syndromes for which you provide services. A list of cancer sites and types associated with each syndrome will also be provided for searching in the directory.

- |  |   |
|--|---|
| <input type="checkbox"/> Adenomatous polyposis, familial | <input type="checkbox"/> Multiple endocrine neoplasia 2 |
| <input type="checkbox"/> Ataxia-telangiectasia           | <input type="checkbox"/> Neurofibromatosis 1            |
| <input type="checkbox"/> Basal cell nevus syndrome       | <input type="checkbox"/> Neurofibromatosis 2            |
| <input type="checkbox"/> Bloom syndrome                  | <input type="checkbox"/> Osteochondromatosis            |
| <input type="checkbox"/> Breast/other (BRCA2)            | <input type="checkbox"/> Pancreatic cancer, familial    |
| <input type="checkbox"/> Breast/ovarian (BRCA1)          | <input type="checkbox"/> Paraganglioma, familial        |
| <input type="checkbox"/> Carcinoid syndrome, familial    | <input type="checkbox"/> Peutz-Jeghers syndrome         |
| <input type="checkbox"/> Carney syndrome                 | <input type="checkbox"/> Prostate cancer, familial      |
| <input type="checkbox"/> Chordoma, familial              | <input type="checkbox"/> Renal cancer, familial         |
| <input type="checkbox"/> Colon (HNPCC)                   | <input type="checkbox"/> Retinoblastoma, hereditary     |
| <input type="checkbox"/> Cowden syndrome                 | <input type="checkbox"/> Rothmund-Thomson syndrome      |
| <input type="checkbox"/> Esophagus, with tylosis         | <input type="checkbox"/> Testicular carcinoma, familial |
| <input type="checkbox"/> Fanconi anemia                  | <input type="checkbox"/> Tuberous sclerosis complex     |
| <input type="checkbox"/> Gastric cancer, familial        | <input type="checkbox"/> Von Hippel-Lindau syndrome     |
| <input type="checkbox"/> Hodgkin lymphoma, hereditary    | <input type="checkbox"/> Werner syndrome                |
| <input type="checkbox"/> Li-Fraumeni syndrome            | <input type="checkbox"/> Wilms tumor, hereditary        |
| <input type="checkbox"/> Melanoma, hereditary            | <input type="checkbox"/> Xeroderma pigmentosum          |
| <input type="checkbox"/> Multiple endocrine neoplasia 1  |   |

## 9. Memberships

Please indicate your membership in any of the following national societies or special interest groups.

- American College of Medical Genetics (ACMG)
- American Psychological Association (APA)
- American Society of Clinical Oncology (ASCO)
- American Society of Human Genetics (ASHG)
- Collaborative Group of the Americas on Inherited Colorectal Cancer (CGA-ICC)
- International Society for Gastrointestinal Hereditary Tumors (InSiGHT)
- International Society of Nurses in Genetics (ISONG)
- NSGC Special Interest Group in Cancer
- National Society of Genetic Counselors (NSGC)

- ONS Cancer Genetics Special Interest Group
- Oncology Nursing Society (ONS)

## 10. Completion

When you have reviewed the information above and made any necessary changes, please select the appropriate button to submit your reply.

**Update My Record**

Please update my profile with the changes I have made.

**No Changes**

No changes are required.

