


Public reporting burden for this collection of information is estimated to vary from 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. **An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number.** Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: NIH, Project Clearance Branch, 6705 Rockledge Drive, MSC 7974, Bethesda, MD 20892-7974, ATTN: PRA (0925-xxxx). Do not return the completed form to this address.

## Filling out PDF Forms

This PDF form contains “**roll-over** or **double-click**” help functionality.

This form allows you to enter data directly onto the screen. After completing the form, you are able to print the document so that you can fax/mail the document.

To fill out a form:

1. Select the hand tool. 
2. Position the pointer inside a field, and click to type text.
3. After entering text or selecting a check box, do one of the following:
  - Press tab to accept the form field change and go to the next form field.
  - Press Shift+Tab to accept the form field change and go to the previous form field.
  - Press Enter (Windows) or Return (Mac OS) to accept the form field change and deselect the current form field.
4. Once completed, print the form.

## REQUEST FOR CLINICAL BROCHURE

To request a copy of a Clinical Brochure for an IND, please complete the information below and **fax this form the CTSU Data Center at 1-888-691-8039**. Following review and approval of this application, a copy of the brochure will be mailed to the address you provide below. Please allow 7-10 business days for processing and mailing of supply requests.

**Date:** \_\_\_\_\_

**Investigator Name and Investigator #:**

\_\_\_\_\_  
*Name*

\_\_\_\_\_  
*NCI investigator #*

**Name and phone # of person completing this form:**

\_\_\_\_\_  
*Name*

(\_\_\_\_\_)\_\_\_\_\_  
*phone #*

**Brochures requested:**

PROTOCOL NUMBER	DRUG NAME	NSC NUMBER

**Name and address (express mail) where document(s) should be sent:**

**Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_  
\_\_\_\_\_

**City, State, Zip:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**Phone:** (\_\_\_\_\_) \_\_\_\_\_

NCI Investigator number verified?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<b>CTSUS use only</b>
PMB investigator status is active?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Active on at least one Group Roster?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Verified by _____	Date _____		
Shipment date: _____			
Comment: _____			