



**Cancer Therapy
 Evaluation Program**

Collection of this information is authorized under 21 CFR 312.53. Collection of this information serves two purposes. The first is to identify qualified investigators and associates to participate in clinical investigations at the National Cancer Institute. This information may be disclosed to researchers for research purposes, sponsors of clinical trials, the applicable Institutional Review Board, National Cancer Institute, Food and Drug Administration's Center for Drug Evaluation and Research and Center for Biologics Evaluation and Research, and the Department of Health and Human Services. The second purpose is to ensure that investigational agents are under the control and accounted for by a competent authority. Submission of this information is voluntary, however, in order for us to qualify you

to conduct a study in accordance with the relevant, current protocol(s), you must complete all fields.

Public reporting burden for this collection of information is estimated to average 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 (0925-0613). Do not return the completed form to this address.

SUPPLEMENTAL INVESTIGATOR DATA FORM

Date (MM/DD/YYYY): ___ / ___ / ___

Sections 1 – 12: REQUIRED INFORMATION (Collected for all investigators participating in CTEP-sponsored clinical trials.)

1. Investigator Name (Last, First, Middle, Suffix):		2. Degree(s):	3. CTEP Investigator ID:	
4. Date of Birth (MM/YYYY): ___ / ___ / ___	5. Provider No. (NPI):	6. Are you currently licensed to practice medicine? <input type="checkbox"/> YES <input type="checkbox"/> NO		
7. Primary Specialty Practice(s): Check all that apply.	Board Eligible:	Board Certified:	Board Eligible: Board Certified:	
	Anatomic and/or Clinical Pathology	<input type="checkbox"/>	<input type="checkbox"/>	Obstetrics and Gynecology <input type="checkbox"/> <input type="checkbox"/>
	Clinical Genetics	<input type="checkbox"/>	<input type="checkbox"/>	Orthopedic Surgery <input type="checkbox"/> <input type="checkbox"/>
	Colon and Rectal Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Otolaryngology <input type="checkbox"/> <input type="checkbox"/>
	Dermatology	<input type="checkbox"/>	<input type="checkbox"/>	Pediatric Hematology-Oncology <input type="checkbox"/> <input type="checkbox"/>
	Diagnostic Radiology	<input type="checkbox"/>	<input type="checkbox"/>	Pediatrics <input type="checkbox"/> <input type="checkbox"/>
	Family Practice	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatry <input type="checkbox"/> <input type="checkbox"/>
	Gastroenterology	<input type="checkbox"/>	<input type="checkbox"/>	Public Health and General Preventative Medicine <input type="checkbox"/> <input type="checkbox"/>
	Gynecological Oncology	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Oncology <input type="checkbox"/> <input type="checkbox"/>
	Hematology	<input type="checkbox"/>	<input type="checkbox"/>	Surgery <input type="checkbox"/> <input type="checkbox"/>
	Internal Medicine	<input type="checkbox"/>	<input type="checkbox"/>	Surgical Oncology <input type="checkbox"/> <input type="checkbox"/>
	Medical Oncology	<input type="checkbox"/>	<input type="checkbox"/>	Thoracic Surgery <input type="checkbox"/> <input type="checkbox"/>
	Neurological Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Urology <input type="checkbox"/> <input type="checkbox"/>
	Neurology	<input type="checkbox"/>	<input type="checkbox"/>	Other _____ <input type="checkbox"/> <input type="checkbox"/>
8. Have you received training in:	Completion of this training is mandatory for all CTEP-registered investigators.			
"Protection of Human Research Participants"?	<input type="checkbox"/> YES DATE COMPLETED (MM/YYYY): ___ / ___ / ___			
<i>In sections 9 – 12, use this side to either enter new information or view current information.</i>		<i>In sections 9 – 12, use this side to make changes to current information only.</i>		
9. Office Address: The office address and contact information will be used for receipt of all official correspondence.				
Institution: _____	Institution: _____			
Internal Office: _____	Internal Office: _____			
Street Address: _____	Street Address: _____			
Street Address: _____	Street Address: _____			
City: _____	City: _____			
State/Province: _____	State/Province: _____			
Zip/Postal Code: _____	Zip/Postal Code: _____			
Country: _____	Country: _____			
Office Phone No.: _____	Office Phone No.: _____			
Office FAX No.: _____	Office FAX No.: _____			
Office E-mail: _____	Office E-mail: _____			
10. Research Contact: Provide a phone number and email address, suitable for display on a publicly accessible website (e.g., www.cancer.gov), which can be used by a patient to contact the investigator's research staff to inquire about clinical trials approved by their IRB and open for enrollment at their institution.				
Research Contact Phone No. _____	Research Contact Phone No. _____			
Research Contact E-mail address _____	Research Contact E-mail address _____			



11. Primary Shipping Address: The primary shipping address will be used for receipt of all CTEP-supplied investigational agents.

Institution: _____
Internal Office: _____
Street Address: _____
Street Address: _____
City: _____
State/Province: _____
Zip/Postal Code: _____
Country: _____

Institution: _____
Internal Office: _____
Street Address: _____
Street Address: _____
City: _____
State/Province: _____
Zip/Postal Code: _____
Country: _____

Shipping Designee: Provide name of shipping designee (preferably a pharmacist) approved to order and receive CTEP-supplied investigational agents.

Shipping Designee Name: _____
Shipping Designee Phone No.: _____
Shipping Designee FAX No.: _____
Shipping Designee E-mail: _____

Shipping Designee Name: _____
Shipping Designee Phone No.: _____
Shipping Designee FAX No.: _____
Shipping Designee E-mail: _____

CTEP USE ONLY: PSD SD IA

12. Ordering Designee(s): Provide name(s) of ordering designee(s) approved to order CTEP-supplied investigational agents. **Note that a "Clinical Drug Request (CDR) Form" for a CTEP-supplied agent must be signed by either the investigator, the authorized shipping designee (from item #11), or an ordering designee (from item #12). An ordering designee must use the primary shipping address (from item #11).**

A. Ordering Designee Name: _____
Ordering Designee Phone No.: _____
Ordering Designee Fax No.: _____
Ordering Designee E-mail: _____

A. Ordering Designee Name: _____
Ordering Designee Phone No.: _____
Ordering Designee Fax No.: _____
Ordering Designee E-mail: _____

B. Ordering Designee Name: _____
Ordering Designee Phone No.: _____
Ordering Designee Fax No.: _____
Ordering Designee E-mail: _____

B. Ordering Designee Name: _____
Ordering Designee Phone No.: _____
Ordering Designee Fax No.: _____
Ordering Designee E-mail: _____

C. Ordering Designee Name: _____
Ordering Designee Phone No.: _____
Ordering Designee Fax No.: _____
Ordering Designee E-mail: _____

C. Ordering Designee Name: _____
Ordering Designee Phone No.: _____
Ordering Designee Fax No.: _____
Ordering Designee E-mail: _____

- Please be sure you have also included:
1. Completed FDA Form 1572 with original signature.
 2. Current Curriculum Vitae (CV).
 3. Completed FinaCTEPal Disclosure Form with original signature.

I certify that the information on this "Supplemental Investigator Data Form" is true and correct to the best of my knowledge.

Investigator: _____ Date: _____
(Signature)

Section	INSTRUCTIONS FOR COMPLETING THE "SUPPLEMENTAL INVESTIGATOR DATA FORM"
1.	Investigator Name: Provide legal last name, first name, middle initial or name, and suffix (if applicable).
2.	Degree(s): Provide degree(s) (e.g., M.D., D.O., foreign M.D. equivalent).
3.	CTEP Investigator ID: Provide the unique CTEP investigator number assigned to the investigator by the Pharmaceutical Management Branch (PMB), CTEP, DCTD, CTEP at the time of initial registration. <i>(If an investigator has never registered to participate in CTEP-sponsored clinical trials, leave field blank. An CTEP Investigator ID will be assigned by the PMB as part of the registration process.)</i>
4.	Date of Birth: Indicate the investigator's date of birth (in MM/YYYY format).
5.	Provider No. (NPI): Indicate the investigator's National Provider Identifier (NPI).
6.	Medical License: Indicate if the investigator is currently licensed to practice medicine.
7.	Primary Specialty Practice(s): Indicate the investigator's primary specialty practice(s). Board Eligible: Indicate if the investigator is eligible for Board Certification in the primary specialty practice(s) selected. Board Certified: Indicate if the investigator is Board Certified in the primary specialty practice(s) selected.
8.	Investigator Training: Indicate if the investigator has completed the NIH-mandated training in the protection of human research participants, including date completed (in MM/YYYY format). If needed, additional information and online training are available at http://phrp.nihtraining.com . The online training takes approximately one hour to complete. Completion of protection of human research participants training is mandatory for ALL CTEP-registered investigators.
9.	Office Address: The office address will be used for receipt of all official correspondence (e.g., annual registration and protocol documents). Include institution, internal office, street, city, state/province, zip/postal code, and country. Office Phone No.: Provide daytime phone number at which the investigator can be reached during normal business hours, including area code. Investigators from outside the United States should also include the country code. Office Fax No.: Provide Fax number at which the investigator usually receives faxes, including area code. Investigators from outside the United States should also include the country code. Office E-mail: Provide E-mail address at which the investigator usually receives e-mail. This address will be used to send information regarding protocols, investigator brochures, stock recovery letters, investigator expiry information, and general information for the investigator.
10.	Research Contact: Provide a phone number and email address, suitable for display on a publicly accessible website (e.g., www.cancer.gov), which can be used by a patient to contact the investigator's research staff to inquire about clinical trials approved by their IRB and open for enrollment at their institution.
11.	Primary Shipping Address: The primary shipping address will be used for receipt of all CTEP-supplied investigational agents. Include institution, internal office, street, city, state/province, zip/postal code, and country. Shipping Designee: Provide name of shipping designee (preferably a pharmacist) approved to order and receive CTEP-supplied agents. <i>Note that a "Clinical Drug Request (CDR) Form" for a CTEP-supplied agent must be signed by either the investigator, the authorized shipping designee (from item #11), or an ordering designee (from item #12).</i> Shipping Designee Phone No.: Provide daytime phone number at which the shipping designee can be reached during normal business hours, including area code. Shipping designees from outside the United States should also include the country code. Shipping Designee Fax No.: Provide Fax number at which the shipping designee usually receives faxes, including area code. Shipping designees from outside the United States should also include the country code. Shipping Designee E-mail: Provide E-mail address at which the shipping designee usually receives e-mail. This address will be used to send information regarding drug shipments, protocols, stock recovery letters, and general information for shipping designees.
12.	Ordering Designee(s): Provide name(s) of ordering designee(s) approved to order CTEP-supplied agents. <i>Note that a "Clinical Drug Request (CDR) Form" for a CTEP-supplied agent must be signed by either the investigator, the authorized shipping designee (from item #11), or an ordering designee (from item #12). An ordering designee must use the primary shipping address (from item #11).</i> Ordering Designee Phone No.: Provide daytime phone number at which the ordering designee can be reached during normal business hours, including area code. Ordering designees from outside the United States should also include the country code. Ordering Designee Fax No.: Provide Fax number at which the ordering designee usually receives faxes, including area code. Ordering designees from outside the United States should also include the country code. Ordering Designee E-mail: Provide E-mail address at which the ordering designee usually receives e-mail. This address will be used to send information regarding drug shipments, protocols and general information for ordering designees.