


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-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.



Data Clarification Form

To: \_\_\_\_\_ Date: \_\_\_\_\_ **Site:** \_\_\_\_\_  
 Investigator: \_\_\_\_\_ Patient #: \_\_\_\_\_ Reviewer: \_\_\_\_\_  
 DCF ID #: \_\_\_\_\_ DCF Print Status: \_\_\_\_\_ Document #: \_\_\_\_\_

Form Name	Visit Name	Comments	Resolution

CRA Signature: \_\_\_\_\_

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

Investigator Signature (required only if requested in the  
Comments above): \_\_\_\_\_

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

CTSUSU USE ONLY:	
DRA CLOSED: _____	DATE: _____

***Instructions:*** Please return this DCF to the CTSU, signed, dated and accompanied by a completed CTSU Data Transmittal Form. Resolutions/ responses to Comments should be clearly specified in the above Resolution section. Values and units should be specified precisely in the same format as required on the case report form. Any changes made to this DCF should be initialed and dated. Please retain a copy of the signed and dated DCF for the patient's record."