


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 (0925-0753). 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.



## CANCER TRIALS SUPPORTUNIT

### PATIENT ENROLLMENT TRANSMITTAL FORM

CTSUS patient enrollment hours are 9:00 am – 5:30 pm ET – Mon.-Fri. To enroll a patient:

- 1) Complete this cover sheet
- 2) Upload the form to the Regulatory Submission Portal and select the Enrollment/Transfer document type.  
(\*For Emergencies call the CTSUS Help Desk.)
- 3) Call the CTSUS Help Desk with any questions. (1-888-823-5923 or ctsucontact@westat.com)

1. Date:(MM/DD/YYYY) \_\_\_\_\_ / \_\_\_\_\_ /20\_\_\_\_\_ Enrollment Cover sheet plus(\_\_\_\_)
2. Patient is to be enrolled on: \_\_\_\_\_  
*Lead Organization Name and Protocol Number*
3. Enrollment Contact Person: \_\_\_\_\_ Phone: \_\_\_\_\_  
*First name Last name*  
Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_
4. Treating Institution: \_\_\_\_\_  
*Name City State*
5. Treating Institution's NCI code:
6. Treating Physician: \_\_\_\_\_ CTEP ID:       
*First name Last name*
7. Indicate organization to receive enrollment credit: \_\_\_\_\_  
*Organization name*

#### ADDITIONAL INFORMATION (Optional)

For expedited shipping please provide your Federal Express Account Name and Number.\* Account

Number: \_\_\_\_\_

\*Available for selected protocols as outlined in the drug shipment information in the protocol. This information must be completed for each patient enrollment where expedited drug shipment is available.