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NATIONAL CANCER INSTITUTE — Cancer Therapy Evaluation Program

SUPPLEMENTAL INVESTIGATOR DATA FORM

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

Sections 1 – 11: REQUIRED INFORMATION (Collected for all investigators participating in NCI-sponsored clinical trials.)

1. Investigator Name (Last, First, Middle, Suffix):	2. Degree(s):	3. NCI Investigator No.:

4. Date of Birth (MM/YYYY): __ __ / __ __ __ __	5. Provider No. (UPIN):	6. Are you currently licensed to practice medicine? ☐ YES ☐ NO

7. Primary Specialty Practice(s): Check all that apply.	Board Eligible:	Board Certified:		Board Eligible:	Board Certified:
Anatomic and/or Clinical Pathology	☐	☐	Obstetrics and Gynecology	☐	☐
Clinical Genetics	☐	☐	Orthopedic Surgery	☐	☐
Colon and Rectal Surgery	☐	☐	Otolaryngology	☐	☐
Dermatology	☐	☐	Pediatric Hematology-Oncology	☐	☐
Diagnostic Radiology	☐	☐	Pediatrics	☐	☐
Family Practice	☐	☐	Psychiatry	☐	☐
Gastroenterology	☐	☐	Public Health and General Preventative Medicine	☐	☐
Gynecological Oncology	☐	☐	Radiation Oncology	☐	☐
Hematology	☐	☐	Surgery	☐	☐
Internal Medicine	☐	☐	Surgical Oncology	☐	☐
Medical Oncology	☐	☐	Thoracic Surgery	☐	☐
Neurological Surgery	☐	☐	Urology	☐	☐
Neurology	☐	☐	Other _____	☐	☐

8. Have you received training in: ***Completion of this training is mandatory for all NCI-registered investigators.***

"Protection of Human Research Participants"? ☐ YES DATE COMPLETED (MM/YYYY): __ __ / __ __ __ __

In sections 9 – 11, use this side to either enter new information or view current information.

In sections 9 – 11, use this side to make changes to current information only.

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

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:

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

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

NCI USE ONLY: ☐ PSD ☐ SD ☐ IA

11. Ordering Designee(s): Provide name(s) of ordering designee(s) approved to order CTEP-supplied 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 #10), or an ordering designee (from item #11). An ordering designee must use the primary shipping address (from item #10).**

A. Ordering Designee Name:	A. Ordering Designee Name:
Ordering Designee Phone No.:	Ordering Designee Phone No.:
Ordering Designee Fax No.:	Ordering Designee Fax No.:
Ordering Designee E-mail:	Ordering Designee E-mail:
B. Ordering Designee Name:	B. Ordering Designee Name:
Ordering Designee Phone No.:	Ordering Designee Phone No.:
Ordering Designee Fax No.:	Ordering Designee Fax No.:
Ordering Designee E-mail:	Ordering Designee E-mail:
C. Ordering Designee Name:	C. Ordering Designee Name:
Ordering Designee Phone No.:	Ordering Designee Phone No.:
Ordering Designee Fax No.:	Ordering Designee Fax No.:
Ordering Designee E-mail:	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 Financial 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.	**NCI Investigator No.:** Provide the unique NCI investigator number assigned to the investigator by the Pharmaceutical Management Branch (PMB), CTEP, DCTD, NCI at the time of initial registration. ***(If an investigator has never registered to participate in NCI-sponsored clinical trials, leave field blank. An NCI Investigator No. will be assigned by the PMB as part of the registration process.)***
4.	**Date of Birth:** Indicate the investigator's date of birth (in MM/YYYY format).
5.	**Provider No. (UPIN):** Indicate the investigator's Unique Physician Identification Number (UPIN). ***This information is optional and is for internal reporting only.***
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 Eligibile:** Indicate if the investigator is eligible for Board Certification in the primary specialty practice selected. **Board Certified:** Indicate if the investigator is Board Certified in the primary specialty practice 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://cme.cancer.gov/c01/. The online training takes approximately one hour to complete. ***Completion of protection of human research participants training is mandatory for ALL NCI-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 and general information for the investigator.
10.	**Primary Shipping Address:** The primary shipping address will be used for receipt of all CTEP-supplied 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 for the investigator. ***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 #10), or an ordering designee (from item #11).*** **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 protocols and general information for shipping designees.
11.	**Ordering Designee(s):** Provide name(s) of ordering designee(s) approved to order CTEP-supplied agents for the investigator. ***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 #10), or an ordering designee (from item #11). An ordering designee must use the primary shipping address (from item #10).*** **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 protocols and general information for ordering designees.