

National Institutes of Health
National Cancer Institute

Division of Cancer Treatment and Diagnosis
Cancer Therapy Evaluation Program

Address: (Including Institution)

Check here if returned receipt should be mailed to the above address, OR fill in a fax number below

FOR NCI USE ONLY

Return No.:

Signature of Authorizing Official:

Date of Authorization:

Return Drug List

Return only agents supplied by the National Cancer Institute

The agents listed below were ordered by (one investigator per form only):
Dr.

NCI Investigator No.:

NSC Number	Agent Name	NCI Protocol Number	Strength, Unit, & Dose (Specify vials, capsules, or tablets)	Lot Number (or Patient ID for Blinded Trial)	Manufacturer	Quantity (Specify whole or partial containers)	Container Number	Action
1								
Reason for return: <input type="checkbox"/> Agent expired <input type="checkbox"/> All patient(s) off treatment <input type="checkbox"/> Protocol complete <input type="checkbox"/> Other:								
2								
Reason for return: <input type="checkbox"/> Agent expired <input type="checkbox"/> All patient(s) off treatment <input type="checkbox"/> Protocol complete <input type="checkbox"/> Other:								
3								
Reason for return: <input type="checkbox"/> Agent expired <input type="checkbox"/> All patient(s) off treatment <input type="checkbox"/> Protocol complete <input type="checkbox"/> Other:								
4								
Reason for return: <input type="checkbox"/> Agent expired <input type="checkbox"/> All patient(s) off treatment <input type="checkbox"/> Protocol complete <input type="checkbox"/> Other:								
5								
Reason for return: <input type="checkbox"/> Agent expired <input type="checkbox"/> All patient(s) off treatment <input type="checkbox"/> Protocol complete <input type="checkbox"/> Other:								
6								
Reason for return: <input type="checkbox"/> Agent expired <input type="checkbox"/> All patient(s) off treatment <input type="checkbox"/> Protocol complete <input type="checkbox"/> Other:								

Date Received:

INSTRUCTIONS:

1. Properly complete all sections to receive credit for the return.
2. Type all information-one item, lot, or protocol per line.
3. DO NOT mark in shaded areas.
4. Investigator signature or signature of individual preparing this form:
5. Pack the agent(s) well to minimize breakage and leakage.
6. All agents may be returned via room temperature
7. Enclose the completed list with the agent(s) and return to:

✂

NCI Clinical Repository
627 Lofstrand Lane
Rockville, MD 20850
Attn: Returns

Signature / Printed Name _____ Date _____

Title _____ Phone No. _____

FOR NCI USE ONLY

RETURN RECEIPT: To obtain a return receipt by fax, provide your number in the space below.
