

# INVESTIGATOR DATABASE FORM



Thank you for joining our Investigator Network. Please complete all sections and fax back to **631-474-8534** at your earliest convenience.

A. INVESTIGATOR INFORMATION			
Potential Investigator Name:		Specialty:	
Company Name / Institution:			
Street Address:			
City:		State:	Zip Code:
Telephone:	Fax:	Email:	
1. Is the investigator board certified? If Yes, specify area:			<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Will studies be conducted at the location listed above? If No, specify:			<input type="checkbox"/> Yes <input type="checkbox"/> No

B. CLINICAL RESEARCH EXPERIENCE	
1. Does the investigator have clinical research experience? If Yes, what year did this investigator start research? _____ (e.g. 1979)	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. What is the approximate number of trials currently being conducted by the investigator?	
3. Has the investigator ever been audited by the FDA? If Yes, was a 483 issued? <b>If yes, please attached a copy of the 483(s).</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
4. If you would like to be contacted for future studies, please list all therapeutic areas previously conducted or of interest:	

C. SITE INFORMATION	
1. How many sub-investigators are currently at the site?	

Please list below all sub-investigators at the site.			
2. How many coordinators are currently at the site?		2a. How many are certified?	
3. Does the site have clinical research experience? If Yes, what year did the site start research? _____ (e.g. 1979)			<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Has the site ever been audited by the FDA? If Yes, was a 483 issued? <b>If yes, please attached a copy of the 483(s).</b>			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
5. How would you classify the site?	<input type="checkbox"/> Hospital <input type="checkbox"/> University	<input type="checkbox"/> Private Practice <input type="checkbox"/> SMO	<input type="checkbox"/> Dedicated Research Site <input type="checkbox"/> Other _____
6. What is the site's setting?	<input type="checkbox"/> Urban <input type="checkbox"/> Rural	<input type="checkbox"/> Suburban	Setting's population size:
7. What is the closest airport to your site?			
8. Approximately how long does it take to finalize Clinical Trial Agreements?		<input type="checkbox"/> ≤ 1 week <input type="checkbox"/> ≤ 3 weeks	<input type="checkbox"/> ≤ 2 weeks <input type="checkbox"/> ≥ 1 month
9. Are there any satellite offices where studies would be conducted? If Yes, specify miles apart from primary location:			<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Is there locked storage on site?			<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Is there sufficient storage on site for CRF binders post study archiving?			<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Is there sufficient storage for retain samples?			<input type="checkbox"/> Yes <input type="checkbox"/> No

D. IRB INFORMATION			
1. What type of IRB does the site use?	<input type="checkbox"/> Local <input type="checkbox"/> Central	Local IRB Name:	
Street Address:			
City:		State:	Zip Code:
2. Timeframe for approvals?	2a. How often does the IRB Meet?	2b. Next scheduled IRB Meeting?	

E. CONTRACT CONTACT INFORMATION		
Contract Contact:	Telephone:	Fax:
Email:		

F. SITE MANAGER INFORMATION		
Contact Name and Title:	Telephone:	Fax:
E-mail:		

G. INVESTIGATOR/SITE REFERRALS TO BE ADDED TO THE DATABASE		
PI / Institution Name	Phone Number	Fax Number

H. ADDITIONAL COMMENTS