Investigator Background Information Form

(Please include all information not information not included on your CV.)

Investigator Information / Primary Office Address:

Last Name: _____ First Name: _____ MI: ____
Prefix (Dr, etc) _____ Suffix (MD) ___ Title: _____
Phone: _____ Ext: ____ Fax: _____
Cellular/Pager: _____ Email: _____
Institution/Facility _____
Address/Suite: _____
City: _____ State/Province _____
Postal Code: _____ Country: _____
Date of Birth: _____

Do you perform studies through a company or separate organization? Yes_____ No _____

Organization: _____
Contact Name: _____
Contact Phone: _____

Medical Specialties:
Specialty: _____
Subspeciality:_____

Trial Experience

Do you have clinical trial experience? ☐ Yes ☐ No
If Yes, what phase(s) of research have you participated in (check all that apply)?
☐ Phase I ☐ Phase II ☐ Phase III ☐ Phase IV

If Yes, how long have you done clinical research? _____
Have you done clinical research within the past year? ☐ Yes ☐ No
How many trials are you conducting now? _____
Did you meet enrollment goals or are you on target with enrollment for some, All or None of these trials? _____
Can you pre-screen patients to identify a patient population for a particular trial? ☐ Yes ☐ No
When you pre-screen patients, do you use a computer program or chart review? _____
Have you ever had an adult? ☐ Yes ☐ No
If Yes, what was the result? _____

What companies have you done clinical trials with (Please list all)?

_____

_____

Please list last 5 trials you have participated in:

Trial Name	Date	Indication	Sponsor	Enrollment Numbers

Can you do inpatient and/or outpatient trials? ___In ___Out ___Both

Do you have a database of patients? ___ Yes ___ No

Do you conduct research within your Private Practice? ___ Yes ___ No

Do you conduct research within a Hospital you are affiliated with? ___ Yes ___ No

Do you conduct research within a University you are affiliated with? ___ Yes ___ No

Do you have any Continuing Care affiliation? ___ Yes ___ No

Do you have any Assisted Living affiliation? ___ Yes ___ No

Do you have any Skilled Nursing Home affiliation? ___ Yes ___ No

Patient Population

Pediatric ☐ Yes ☐ No

0-1 months: _____ patients 1 mo-2 years: _____ patients

2-12 years: _____ patients 12-17 years: _____ patients

Adult (18-64) ☐ Yes ☐ No Number of Patients: _____

Geriatric (65+) ☐ Yes ☐ No Number of Patients: _____

Percent of Patients: Male ___% Female ___%

Total Number of Patients you have access to: _____

Ethnic Background:

Approximate **percent** of:

Caucasian (Non Hispanic) Patients: ____%

African Patients: ____%

Hispanic Patients: ____%

Asian Patients: ____%

Aboriginal/Native Patients: ____%

Other ethnic background patients: ____%

Investigator Education
(If not included on your CV)

Undergraduate
School: _____
Year Graduated: _____
Major: _____
Degree: _____

Medical Examination
School: _____
Year Graduated: _____
Degree: _____

Internship
Institution: _____
Year Completed: _____

Residency
Institution: _____
Year Completed: _____

2nd Residency
Institution: _____
Year Completed: _____

Fellowship
Institution: _____
Year Completed: _____
Medical Specialty: _____

Post Graduate
School: _____
Year Graduated: _____
Major: _____
Degree: _____

Additional Training
_____
_____
_____
_____
_____

Medical License Number: _____ State/Province: _____
Medical License Number: _____ State/Province: _____
Medical License Number: _____ State/Province: _____

Site Information

Secure Drug Storage	☐ Yes	☐ No
Pharmacy	☐ Yes	☐ No
Secure Record Storage	☐ Yes	☐ No

Refrigerator	☐ Yes	☐ No
Freezer (40 to 70F below zero)	☐ Yes	☐ No
Freezer (20F below zero)	☐ Yes	☐ No
Cardiac Stress Testing	☐ Yes	☐ No
Clinical Lab (phlebotomy)	☐ Yes	☐ No
Micro Lab	☐ Yes	☐ No
Centrifuge	☐ Yes	☐ No
Radiology	☐ Yes	☐ No
Access to ER	☐ Yes	☐ No

Other (please specify):

_____
_____
_____
_____
_____

Medical Employment History

(Past 5 years, if not included on your CV)

Position Held	Location (City, State/Province)	Years of Employment

_____ _____

Physician Signature Date