

CALGB: ROSTER UPDATE REQUEST FORM

CALGB Form: A-001

INSTRUCTIONS: Complete form and submit to the CALGB Central Office via fax at (312) 345-0117.

Action (Mark one with an X.) 1. Addition 2. Correction 3. Deletion

NCI Investigator's Identification No. _____

Name _____
Last First M.I. Suffix (e.g., Jr., III)

Salutation _____ Degree _____ Date of birth ____/____/____ SSN ____ - ____ - ____
(e.g., Mr., Mrs., Dr., Dean) (e.g., MD, DDS, Ph.D., BSN) MM DD YYYY

Race <input type="checkbox"/> 1. White <input type="checkbox"/> 3. Black or African American <input type="checkbox"/> 4. Asian <input type="checkbox"/> 5. Native Hawaiian or Other Pacific Islander <input type="checkbox"/> 6. American Indian or Alaskan Native <input type="checkbox"/> 99. Unknown	Sex <input type="checkbox"/> 1. Male <input type="checkbox"/> 2. Female
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Institutional Role

<input type="checkbox"/> 1. Cytogeneticist <input type="checkbox"/> 2. Chief of Radiology <input type="checkbox"/> 3. Chief of Surgery <input type="checkbox"/> 4. Lead CRA <input type="checkbox"/> 5. CRA <input type="checkbox"/> 6. Psycho-Oncology Coordinator <input type="checkbox"/> 7. Surgical Coordinator	<input type="checkbox"/> 8. Surgical CRA <input type="checkbox"/> 9. Oncology Nursing <input type="checkbox"/> 10. Transplant Director <input type="checkbox"/> 11. Pharmacist <input type="checkbox"/> 12. Principal Investigator <input type="checkbox"/> 13. Investigator <input type="checkbox"/> 14. Responsible Investigator	<input type="checkbox"/> 15. Pharmacy Coordinator <input type="checkbox"/> 16. Transplant Coordinator <input type="checkbox"/> 17. CCOP Responsible Investigator <input type="checkbox"/> 18. Laboratory Technician <input type="checkbox"/> 19. Radiation Oncology Coordinator <input type="checkbox"/> 20. Pathology Coordinator
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Specialty

<input type="checkbox"/> 1. Hematology <input type="checkbox"/> 2. Oncology <input type="checkbox"/> 3. Surgery <input type="checkbox"/> 4. Pathology <input type="checkbox"/> 5. Immunology <input type="checkbox"/> 6. Cytogenetics	<input type="checkbox"/> 7. Statistics <input type="checkbox"/> 8. Psychiatry <input type="checkbox"/> 9. Epidemiology <input type="checkbox"/> 10. Hematology/Oncology <input type="checkbox"/> 11. Radiation Oncology <input type="checkbox"/> 12. Oncology Nursing	<input type="checkbox"/> 13. Oncology Nursing/Data Management <input type="checkbox"/> 14. Data Management <input type="checkbox"/> 15. Pharmacist <input type="checkbox"/> 16. Administration <input type="checkbox"/> 17. Psycho-Oncology <input type="checkbox"/> 18. Other, specify: _____
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MAILING ADDRESS Secondary Address? No Yes Broadcast? No Yes

Institution Name _____
Department _____
Street _____
P.O. Box/Suite _____ City _____ State _____
Country _____ Postal Code _____
Phone #1 _____ Ext. _____ Phone # 2 _____ Ext. _____
Fax Number _____ Email Address _____

FOR INVESTIGATOR ONLY

Does investigator have a private practice? No Yes
If Yes, has the Investigator submitted a Non-institutional Investigator Assurance (NIA)/Unaffiliated Investigator Agreement for Independent Investigator (All)? No Yes
Certification on Protection of Human Subject Training Type: _____
Copy of Investigator's 1572 attached? No Yes

FOR PATIENT REGISTRATION ONLY

Will participant be registering patients to CALGB studies? No Yes, please have the PI sign below.
Principal Investigator Name (Please print) _____
Principal Investigator Signature _____
Submitted By: _____ Phone Number _____