



Please Print Legibly and Circle the Options in Blue

Primary Physician: _____ Type of Institution: Academic Center Community Center

Institution Name: _____

Address: _____

City: State: ZIP code: _____

Telephone: Fax: E-Mail Address: _____

Medical Specialty: Area of Sub-Specialty: Degree(s): _____

Study Coordinator: Name: Phone: E-Mail Address: _____

Contracts Manager: Name: Phone: E-Mail Address: _____

Can your Site Use a Central Institutional Review Board? Yes No Unknown

Logistics:

- Who would likely provide ongoing patient care: Medical Oncologist Surgeon
- How many patients with Colon, Ovarian or Lung Cancer do you see per year? Colon ___ Ovarian ___ Lung ___
- Will you agree to an institutional start-up fee and a per-patient-visit fee based on fair market value for reimbursement of your staff's time?* Yes No
*A research agreement with Oncotech must be signed.
- How did you hear about the registry? _____
- Approximately how many patients do you submit for an EDR test in a 12-month time window? _____
- Have you ever been audited by the FDA? Yes No
If yes, during an audit have you ever received a FDA Form 483 Yes No (If yes, attach copies of FDA Form 483.)
- How long does it typically take for a study contract to be processed in your institution? _____
- What is the average time frame in which your IRB meets? Weekly 1-2 Weeks Monthly Other _____
- What are the IRB fees at your site? _____

Indicate Your Interest:

YES I have read the attached information briefly describing the purpose of the registry and the resources necessary and I am interested in participating. Please send me full details. My signature below[†] constitutes agreement that I will hold confidential any information forwarded to me regarding the above referenced program.

[†]Primary Physician Signature: _____

NO I am not interested in participating in this Registry.

Please refer any other physicians who you feel may be interested in this program:

Physician Name: _____ Telephone Number: _____

Only **ONE** form should be filled out per address, as only one Primary Physician will be identified per site.

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Please fax this questionnaire to: (610) 832-7017 Attention: Sandi Combs

For questions about the ArQive™ Registry, please contact us at (877) 720-8886 or exiqonregistry@covance.com