



**INVESTIGATOR BACKGROUND
INFORMATION FORM**
Global

INVESTIGATOR INFORMATION:

<i>Title</i>	<i>Last Name</i>	<i>First Name</i>	<i>Middle Initial</i>	<i>Degree</i>
<i>Medical Specialty: (e.g., Radiology, Neurology, Cardiology, etc.)</i>				

OFFICE/PRACTICE/INSTITUTION ADDRESS (where study patients will be seen):

<i>Institution (Hospital, Clinic or Private Practice name as applicable)</i>		
<i>Department Name (Address Line 2)</i>		
<i>Street Address (Address Line 1)</i>		<i>Town/City</i>
<i>State/Province (if applicable)</i>	<i>Postal Code/Zip Code(if applicable)</i>	<i>Country</i>
<i>Telephone Number (office or mobile)</i>	<i>Fax Number</i>	<i>E-mail Address</i>

PRACTICE TYPE:

<i>Please specify the type of practice you are based in:</i>			
<input type="checkbox"/> Clinic - Group Practice	<input type="checkbox"/> Hospital - Public (Non-Academic)	<input type="checkbox"/> Nursing Home	<input type="checkbox"/> Student Health Centre
<input type="checkbox"/> Clinic - Private	<input type="checkbox"/> Hospital - University (Academic)	<input type="checkbox"/> Private - Group Practice	<input type="checkbox"/> Surgical Centre
<input type="checkbox"/> Clinic - Public Health	<input type="checkbox"/> Hospital - VA/Military (Government)	<input type="checkbox"/> Rehabilitation Facility	<input type="checkbox"/> Trauma Centre
<input type="checkbox"/> Clinic - Hospital Based	<input type="checkbox"/> Managed Health Care	<input type="checkbox"/> Research Centre	<input type="checkbox"/> Urgent Care Centre
<input type="checkbox"/> Emergency Room	<input type="checkbox"/> Mental Health Centre	<input type="checkbox"/> Sleep Lab	<input type="checkbox"/> Hospice-Pallative Care Centre
<input type="checkbox"/> Hospital - Private	<input type="checkbox"/> Military	<input type="checkbox"/> Solo/Private Practice	<input type="checkbox"/> Other, specify:

FACILITY AND PERSONNEL:

Do you have or are you willing to obtain the necessary support staff (research nurse, study coordinator, administrative assistant or etc) and applicable training required to conduct clinical trials?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Can your facility utilize a non-local (central) Institutional Review Board/Ethics Committee for protocol approvals?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

CONTACT FOR NEW TRIALS: (e.g. Networks, Site Management Organizations, Centralized Research Department):

Are you affiliated with a centralized group who coordinates new protocol feasibility other than investigator above?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Should all feasibility contact go through this person? (If not the same as above complete information below)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<i>Organization/Department Name</i>		
<i>Contact Person Name</i>		
<i>Telephone Number</i>	<i>Fax Number</i>	<i>E-mail Address</i>

INDICATION INTERESTS FOR FUTURE CLINICAL TRIALS:

<i>Please list your TOP disease indications or tumor types treated:</i>	
<i>Disease/Indication/Tumor Description</i>	<i>Disease/Indication/Tumor Description</i>

CLINICAL TRIAL PHASE EXPERIENCE:

Please indicate the trial phases you are experienced in (check all that apply)	<input type="checkbox"/> None	<input type="checkbox"/> I	<input type="checkbox"/> II	<input type="checkbox"/> III	<input type="checkbox"/> IV
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When complete please sign this form and then mail or fax it to Site Relations:

PPD • Attn: Haven Chiasson • 1400 Perimeter Park Drive • Morrisville, NC 27560 • IBlandDPA@wilm.ppd.com
Phone Number +1 877 631 5699 • Fax Number +1 919 654 4812 or +1 877 962 3769

For internal PPD Use only: Please forward the fully complete IBI to your country appointed CASCADE Super User for processing.
CTMS Contact # CTMS Account #



Investigator Data Protection Authorisation Form

PPD Development ("PPD") is committed to respecting the privacy of its' clinical research investigators. We recognise that when you choose to provide us with information about yourself, you trust PPD to act in a responsible manner. PPD has enacted internal procedures, which are reviewed and monitored from time to time to ensure that your information is used responsibly and in accordance with applicable law. These procedures require that the processing of personal data, both automated and manual, meet with the following Data Protection Principles:

- be processed fairly and lawfully
- be obtained only for specified and lawful purposes, and not be processed in any incompatible manner
- be adequate, relevant and not excessive
- be accurate and, where necessary, kept up to date
- not be kept for longer than is necessary
- be processed in accordance with the rights of Data Subjects
- be protected by appropriate security measures
- not be transferred to third parties unless adequate level of data protection exist.

Data Processing

All processing of personal data is, by consent, for the purposes listed above and under the control of the Data Controller. Individuals have the right to:

- copies of their data
- correct their data
- prevent processing for direct marketing
- withdraw consent to processing with its consequential effects
- prevent non-core purpose disclosures and
- prevent trans-border disclosures to third parties where there are inadequate data protection arrangements.

Trans-border data flows

PPD may transfer personal data to third parties as required for the conduct of clinical studies. Personal data will only be transferred to third parties following receipt of assurance that the recipient will provide adequate Data Protection arrangements.

Data Controller

All communications, queries and Subject Access Requests which are related to Data Protection issues should be addressed to Michelle Ward, Privacy Officer at 929 North Front Street, Wilmington, NC 28401, USA or e-mailed to ppdprivacy@wilm.ppd.com for action or response on behalf of PPD.

By appending my signature below, I agree that the following information about myself may be retained by PPD in the Global Investigator Database and individual study files, as required.

- investigator name and contact information
- office/practice location, type, amenities and research staff
- medical speciality and patient population information
- affiliation with a Site Management Organisation (SMO) and SMO information
- historical and current information regarding participation in PPD projects
- other relevant information to allow selection for appropriate clinical trials in the future
- select financial information to allow for reimbursement of investigator grants

I understand that the above data will be used for the purpose of conducting clinical trials and may be transferred to the clinical trial sponsor, FDA or other regulatory bodies.

I hereby consent to PPD (the "Data Controller") use, processing and transmission of information relating to me obtained by PPD.

Investigator Name (please print): _____

Investigator Signature: _____ Date _____

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