# Name & Critical Contact Details

|  |  |  |  |
| --- | --- | --- | --- |
| Company/Institution Name:  |  | Phone:  |  |
| Address1:  |  |  Fax Number:  |  |
| Address2:  |  | Mobile/Cell Phone:  |  |
| Email Address: |  |

# Facilities Affiliations

|  |  |  |
| --- | --- | --- |
| Primary Facility | Facility/Department Name | Address |
|  |  |  |
|  |  |  |
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|  |  |  |

Education

|  |  |  |  |
| --- | --- | --- | --- |
| Degree/Certificate | Institution | Specialty | Year Completed |
|  |  |  |  |
|  |  |  |  |
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Professional Experience

|  |  |  |  |
| --- | --- | --- | --- |
| Job Title | Institution/ Department | Year Started | Year Completed |
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License Details

#

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Type of License | License Issuer | Professional License Number | State,Province or Region | Country | Issue Date | Expiration Date |
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# Good Clinical Practice (GCP) Training Details

|  |  |  |  |
| --- | --- | --- | --- |
| Course Provider | Title of Training | Version | Date Completed |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Research Experience

STUDY TYPE

|  |
| --- |
|   **[ ]** Academic **[ ]** Government **[ ]**  Industry **[ ]** Investigator-Initiated   **[ ]** Other / Please Specify:  |

CLINICAL STUDY PHASES

|  |
| --- |
|   **[ ]** Phase I **[ ]** Phase II **[ ]**  Phase III **[ ]** Phase IV  |

THERAPEUTIC AREA(S) OF EXPERTISE

|  |  |
| --- | --- |
| Therapeutic Area | Sub-Therapeutic Area |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
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|  |  |

TOTAL CLINICAL RESEACH EXPERIENCE

|  |  |  |  |
| --- | --- | --- | --- |
| Therapeutic Areas | Sub-Therapeutic Area | Number of Completed Studies | Number of Ongoing Studies |
|  |  |  |  |
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 SIGNATURE (Please follow the direction of the Sponsor in completing this field.)

**By signing this form, I confirm that the information provided on this Abbreviated CV is accurate and reflects my current employment and qualifications:**

N/A

 ***Signature: Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***