# 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

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| --- | --- | --- | --- | --- | --- | --- |
| 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***