



Affiliation Questionnaire

Site Name: _____

CTEP Site Code: _____

Is your site a member of a CCOP or MBCCOP? Yes No

If yes, Name of the CCOP/MBCCOP _____

Principal Investigator: _____

Primary or Financial Site Contact Person: _____

Phone #: _____ Fax #: _____

Email: _____

Address: _____

Please list current research base affiliations/ cooperative groups: _____

Are patients registered through: Central Office or Individual sites?

Are you equipped for online data entry over the internet? Yes No

Do patients have access to the internet in clinic settings? Yes No

Please list Specialties (check all that apply):

- | | | |
|--|---|--|
| <input type="checkbox"/> Bone Marrow Transplant/Post BMT | <input type="checkbox"/> Hospice | <input type="checkbox"/> Sleep Center |
| <input type="checkbox"/> Cancer Screening/ Wellness | <input type="checkbox"/> Medical Oncology | <input type="checkbox"/> Smoking/Tobacco Control |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Pain Control/ Management | <input type="checkbox"/> Surgical Oncology |
| <input type="checkbox"/> Genetic Testing | <input type="checkbox"/> Palliative Care | <input type="checkbox"/> Radiation Therapy |
| <input type="checkbox"/> Other (please list) _____ | | |

Please list Patient Populations (check all that apply):

- | | | | |
|------------------------------------|--|------------------------------------|---------------------------------------|
| <input type="checkbox"/> Adult | <input type="checkbox"/> Breast | <input type="checkbox"/> Brain/CNS | <input type="checkbox"/> Colon |
| <input type="checkbox"/> Pediatric | <input type="checkbox"/> Head & Neck | <input type="checkbox"/> Lung | <input type="checkbox"/> Ovarian/ GYN |
| <input type="checkbox"/> Prostate | <input type="checkbox"/> Other (please list) _____ | | |

What kinds of studies are you looking for? _____

Please include the Principal Investigator Credentialing Packet:

- | | |
|--|---|
| <input type="checkbox"/> Form FDA 1572 | <input type="checkbox"/> Financial Disclosure / Conflict of Interest Form |
| <input type="checkbox"/> Signed & Dated CV | <input type="checkbox"/> Human Protection Training Certificate / Letter |

Please list professional meetings you regularly attend (ASCO, SoCRA, COG, ECOG, etc.):

Please save this form and submit to ccop@epi.usf.edu
Thank you for your interest!