Potential Investigator Questionnaire

Please complete this questionnaire in its entirety. This will allow us to better serve your clinical research needs. Submit additional copies as necessary to capture additional information. Print and fax to: 513-233-2243.

Institution Name: _____

Address: _____

_____

Telephone #: _____ Fax #: _____

E-mail: _____

Primary Contact Person

Name: _____

Title: _____

Site Contracts Negotiator

Name: _____

Title: _____

Address: _____

_____

Telephone #: _____ Fax #: _____

E-mail: _____

Site Regulatory Contact

Name: _____

Title: _____

Address: _____

_____

Telephone #: _____ Fax #: _____

E-mail: _____

Investigator

Name: ____

Title: ____

Board certificates: ______________________________________

Years of clinical trial experience: _____________________________

Number of studies participated as a Principal Investigator: ________________

Number of studies participated as a Sub-investigator: ___________________

Telephone #: ____________________ Fax #: ________________

E-mail: ____

Investigator

Name: ____

Title: ____

Board certificates: ______________________________________

Years of clinical trial experience: _____________________________

Number of studies participated as a Principal Investigator: ________________

Number of studies participated as a Sub-investigator: ___________________

Telephone #: ____________________ Fax #: ________________

E-mail: ____

Investigator

Name: ____

Title: ____

Board certificates: ______________________________________

Years of clinical trial experience: _____________________________

Number of studies participated as a Principal Investigator: ________________

Number of studies participated as a Sub-investigator: ___________________

Telephone #: ____________________ Fax #: ________________

E-mail: ____

Do you have experienced Study Coordinators? ❑Yes ❑No

Study Coordinator

Name: _____

Title: _____

Years of clinical trial experience: _____

Telephone #: _____ Fax #: _____

E-mail: _____

Study Coordinator

Name: _____

Title: _____

Years of clinical trial experience: _____

Telephone #: _____ Fax #: _____

E-mail: _____

Study Coordinator

Name: _____

Title: _____

Years of clinical trial experience: _____

Telephone #: _____ Fax #: _____

E-mail: _____

Site Setting

Check one:

❑ Private Practice ❑ Research Facility ❑ SMO

❑ Private Hospital ❑ VA Facility ❑ University Hospital

Medical Specialties

Areas of Special Interest

Site Experience

Describe your most recent experience with clinical trials in the table below:

Therapeutic Area Trial Date (year)	Number of subjects contracted to enroll	Number of subjects actually enrolled	Length of Enrollment	Number of subjects completed

Has your practice been audited by the FDA? ❑Yes ❑No

If yes, when? _____

Was a 483 issued? ❑Yes ❑No ❑N/A

(If yes, have a copy of the 483 and any response letters available for review upon request.)

Investigational Product

Do all physicians have a current DEA License? ❑Yes ❑No

Does your practice have a locked cabinet and refrigerated storage space for investigational product? ❑Yes ❑No

Does your practice maintain temperature logs for investigational product? ❑Yes ❑No

Regulatory

Number of business days needed to turn around regulatory documents?_____

Can your practice use a central Institutional Review Board (IRB)? ❑Yes ❑No

(If no, provide name of local IRB you would use) _____

How often do they meet? _____

Provide the next three meeting dates _____

Subject Population

Does your practice see non-English speaking subjects? ❑Yes ❑No

Does your practice see pediatric subjects? ❑Yes ❑No

Equipment

Does your practice have emergency equipment/medications and procedures in place for emergency situations? ❑Yes ❑No

If yes, please list:

_____

_____

_____

List the equipment you have available on site (e.g., EKG machine, spirometry equipment, centrifuge, x-ray equipment).

_____	_____	_____
_____	_____	_____
_____	_____	_____

Nearest Hospital

Name of the nearest hospital: _____

Distance to nearest hospital (miles/time):_____

Laboratory

Does your practice have a designated laboratory? ❑Yes ❑No

Is your practice experienced with collecting, storing, and shipping pharmacokinetic (PK) and/or pharmacogenetic (PG) samples? ❑Yes ❑No

Does your practice have a freezer capable of -20 and/or -70 degrees Celsius temperatures?
❑Yes ➡ ❑-20 ❑-70
❑No

Does your practice have a CLIA Waiver? ❑Yes ❑No

If no, will you be able to obtain a CLIA Waiver? ❑Yes ❑No ❑N/A

Medical Records

Does your practice have:

Electronic data capturing (EDC) experience? ❑Yes ❑No

A process for obtaining medical records? ❑Yes ❑No

Electronic records? ❑Yes ❑No

Space for record storage and retention? ❑Yes ❑No

Are medical records accessible during monitoring visits? ❑Yes ❑No

Additional Information

Are you interested in Research Resources, Inc. providing clinical research training and education for your staff? ❑Yes ❑No

Are you interested in Research Resources, Inc. finding clinical trials for your practice?
❑Yes ❑No

Questionnaire completed by: _____

Title: _____

Phone number: _____

Thank you for completing this questionnaire. In addition to the completed questionnaire, please forward a curriculum vitae (CV), medical license, and/or certificate for all persons listed on the first 3 pages of this document via e-mail to info@researchresources.com or via fax to: 513-233-2243.

Confidentiality and Disclosure: Research Resources, Inc. agrees to take all reasonable steps to preserve the confidentiality of all such information and agrees that such information will be made available only to employees, subcontractors, and vendors as shall have a need to know and have executed a written acknowledgment stating that they are a party to the work defined in this agreement for consulting services. Research Resources, Inc. shall hold all such confidential information trust and confidence for Client, both during and after the term of this agreement, and agrees not to disclose to any person, firm or corporation, or use for its own business or benefit, any confidential information obtained from Client during the term of this agreement, without Client's written consent.