

# The Society of Thoracic Surgeons Clinical Trials Investigator Profile

*This form may be sent by e-mail, fax, or regular mail to Michael Kuby, The Society of Thoracic Surgeons, 633 North Saint Clair, Suite 2320, Chicago, Illinois 60611. PH: 312.202.5828. FAX: 312.202.5801. E-mail: mkuby @ sts.org.*

## I. INVESTIGATOR INFORMATION

\* Indicates required field

*Last Name:		*First Name:	M.I.	*Degree1:	Degree2:	Professional Certification(s):
Practice Specialty (check all that apply): <input type="checkbox"/> Adult Cardiac <input type="checkbox"/> General Thoracic <input type="checkbox"/> Congenital				STS Member Number (six digits):		
Title:				Salutation:		
*Address 1:				Address 2:		
*City:				*State:	*Zip/Postal Code: -	
*Phone: - -		Ext:	Fax:		*E-mail:	
Current STS National Database Participant?: <input type="checkbox"/> Yes <input type="checkbox"/> No						
If yes, STS National Database Participation Identification Number (5 digits):						

## II. PRIMARY RESEARCH FACILITY

Please complete for primary facility at which you operate and plan to conduct clinical trials.

*Facility Name:						
Primary Contact Last Name:				Primary Contact First Name:		
*Street Address:					Suite/Floor/Room:	
*City:				*State:	*Zip/Postal Code: -	
*Phone: - -		Ext:	Fax:		*Email Address:	
Setting: <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Both				IRB Type: <input type="checkbox"/> Local <input type="checkbox"/> Central <input type="checkbox"/> Both		
IRB Meeting Frequency: <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other				Does IRB charge a fee? <input type="checkbox"/> Yes <input type="checkbox"/> No		
*Research Coordinator Information						
Last Name:			First Name:			
Title/Role: <input type="checkbox"/> STS National Database Data Manager <input type="checkbox"/> Study Coordinator <input type="checkbox"/> Research Pharmacist <input type="checkbox"/> Medical Technician <input type="checkbox"/> Sub Investigator <input type="checkbox"/> Regulatory <input type="checkbox"/> Other				<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time		
Number of years in clinical research:    yrs				Number of years as a clinical trials coordinator:		
* Research Coordinator Phone: - -		*Extension:		*Fax:	*E-mail:	

### III. SECONDARY RESEARCH FACILITY

Please complete if you operate and plan to conduct trials at an additional facility

*Facility Name:			
Primary Contact Last Name:		Primary Contact First Name:	
*Street Address:			Suite/Floor/Room:
*City:		*State:	*Zip/Postal Code: -
*Phone: - -	Ext:	Fax:	*Email Address:
Setting: <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Both		IRB Type: <input type="checkbox"/> Local <input type="checkbox"/> Central <input type="checkbox"/> Both	
IRB Meeting Frequency: <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other		Does IRB charge a fee? <input type="checkbox"/> Yes <input type="checkbox"/> No	
*Research Coordinator Information Last Name: _____ First Name: _____			
Title/Role: <input type="checkbox"/> STS National Database Data Manager <input type="checkbox"/> Study Coordinator <input type="checkbox"/> Research Pharmacist <input type="checkbox"/> Medical Technician <input type="checkbox"/> Sub Investigator <input type="checkbox"/> Regulatory <input type="checkbox"/> Other		<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time	
Number of years in clinical research:    yrs		Number of years as a clinical trials coordinator:	
* Research Coordinator Phone: - -	*Extension:	*Fax:	*E-mail:

### IV. CLINICAL TRIAL EXPERIENCE

*Indicate all phases of research in which the Investigator has participated: <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> None	
Number of years involved in trials?	Has investigator ever been on a trial steering committee? <input type="checkbox"/> Yes <input type="checkbox"/> No  Has investigator ever been on a data safety monitoring committee? <input type="checkbox"/> Yes <input type="checkbox"/> No

Please list any trials that you are currently conducting.

Sponsor	Number	Trial Name:
Start Date (MO/YR)	Phase <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III	Drug/Device:
Indication/Comments:		

<b>Sponsor</b>	<b>Number</b>	<b>Trial Name:</b>
<b>Start Date (MO/YR)</b>	<b>Phase</b> <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III	<b>Drug/Device:</b>
<b>Indication/Comments:</b>		

<b>Sponsor</b>	<b>Number</b>	<b>Trial Name:</b>
<b>Start Date (MO/YR)</b>	<b>Phase</b> <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III	<b>Drug/Device:</b>
<b>Indication/Comments:</b>		

<b>Sponsor</b>	<b>Number</b>	<b>Trial Name:</b>
<b>Start Date (MO/YR)</b>	<b>Phase</b> <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III	<b>Drug/Device:</b>
<b>Indication/Comments:</b>		

**Please list all of your previous clinical trial experience.**

<b>Sponsor</b>	<b>Number</b>	<b>Trial Name:</b>
<b>Start Date (MO/YR)</b>	<b>Phase</b> <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III	<b>Drug/Device:</b>
<b>Indication/Comments:</b>		

<b>Sponsor</b>	<b>Number</b>	<b>Trial Name:</b>
<b>Start Date (MO/YR)</b>	<b>Phase</b> <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III	<b>Drug/Device:</b>
<b>Indication/Comments:</b>		

<b>Sponsor</b>	<b>Number</b>	<b>Trial Name:</b>
<b>Start Date (MO/YR)</b>	<b>Phase</b> <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III	<b>Drug/Device:</b>
<b>Indication/Comments:</b>		

<b>Sponsor</b>	<b>Number</b>	<b>Trial Name:</b>
<b>Start Date (MO/YR)</b>	<b>Phase</b> <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III	<b>Drug/Device:</b>
<b>Indication/Comments:</b>		

**V. COMMENTS**

Provide any other information relevant to trials:

**VI. OFFICE USE ONLY**

<b>Assigned trial number(s):</b> a) _____ b) _____ c) _____ d) _____ e) _____	<b>Follow up received (date):</b> _____
	<b>Comments:</b>