Directory Information

Please provide the information requested below. The information contained herein is for NCCN purposes only and will not be published without your express written consent below.

Name:

Last *First* *Middle Initial*

Credentials:

MD, DO, PhD, RN, etc.

Titles:

Mailing Address:

Institution Name

Address - line 1

Address - line 2

Address - line 3

City *State* *Zip Code*

E-Mail Address

Telephone Number(s):

Business Office *Cell Phone**

Patient Appointment Scheduling *Pager**

Fax

** Cell phone and pager numbers are for internal NCCN use only. These numbers will not be published in any directories without your express written consent.*

Shipping Address *(if different than above)* :

Institution Name

Shipping Address - line 1

Shipping Address - line 2

Shipping Address - line 3

City *State* *Zip Code*

Patient Address *(if different than above)* :

Patient Address - line 1

Patient Address - line 2

Patient Address - line 3

City *State* *Zip Code*

Directory Information

☐ **I agree that the NCCN may list my name in the NCCN Physician Directory for patient referrals.**

OR

☐ **I do not want my name listed in the NCCN Physician Directory for patient referrals.**

If you agree, which phone number would you like listed? (circle one)

Business Appointment Other

If you agree, which address would you like listed? (circle one)

Mailing Patient

Signature *Date*

Please provide the name(s) and contact information for your administrative support staff:

Name, Title: _____
Phone: _____
E-Mail: _____
Pager: _____
Address: _____

☐ **Include this individual in all correspondence.**

Directory Information

******* The following section relates to your *clinical* interests and practices. Please take a moment to provide the information requested below.**

Do you treat Adult or Pediatric Oncology Patients? (circle one) Adult Pediatric Both

Specialties:
MedOnc, RadOnc, GynOnc, etc.

Specialty Name	Primary Specialty? (Y/N?)	Board Certified? (Y/N?)

Clinical Cancer Practice(s): *(Check all that apply)*

AIDS Related Malignancies	_____	Leukemia	_____
Bone Cancer	_____	Lung Cancers	_____
Brain Cancer	_____	Lymphoma	_____
Breast Cancer	_____	Multiple Myeloma	_____
Cancer Genetics/Familial Risk Assessment	_____	Quality of Life/Supportive Care	_____
Childhood Cancers	_____	Sarcomas	_____
Endocrine/Neuroendocrine Cancers	_____	Skin Cancer – non-Melanoma	_____
Gastrointestinal Cancers	_____	Skin/Melanoma	_____
Gynecological Cancers	_____	Urologic Cancers	_____
Head & Neck Cancers	_____		

Other Areas of Clinical Interest: _____

NCCN Committees/Panels:

Group	Role

******* If you are interested in participating in the NCCN Oncology Research Program, please continue to the next page.**

Otherwise, please return your completed forms to:

NCCN Directory
NCCN
500 Old York Road, Suite 250
Jenkintown, PA 19046
Fax: 215-690-0280

Directory Information

******* The following section relates to the NCCN Oncology Research Program and your *research* interests and practices. If you are interested in becoming an Oncology Research Program Investigator, please take a moment to provide the information requested below.**

Our records indicate that you have not agreed to become an **Oncology Research Program Investigator. Would you like to agree to become** an **Oncology Research Program Investigator at this time?**

Yes No

If yes, please indicate your areas of interest in the following aspects of Oncology Clinical Trials:

Research Cancer Focus: *(Check all that apply)*

AIDS Related Malignancies	_____	Leukemia	_____
Bone Cancer	_____	Lung Cancers	_____
Brain Cancer	_____	Lymphoma	_____
Breast Cancer	_____	Multiple Myeloma	_____
Cancer Genetics/Familial Risk Assessment	_____	Quality of Life/Supportive Care	_____
Childhood Cancers	_____	Sarcomas	_____
Endocrine/Neuroendocrine Cancers	_____	Skin Cancer – non-Melanoma	_____
Gastrointestinal Cancers	_____	Skin/Melanoma	_____
Gynecological Cancers	_____	Urologic Cancers	_____
Head & Neck Cancers	_____		

Other Areas of Research Interest: _____

Study Phase(s): *(Check all that apply)*

Phase I _____ Phase II _____ Phase III _____ Phase IV _____

Treatment Modalities: *(Check all that apply)*

Angiogenesis Inhibitor	_____	Pain	_____
Antithrombotic Therapy	_____	Palliative Care	_____
Biologic Therapy	_____	Peripheral Cell Transplant	_____
Bone Marrow Transplant	_____	Radiation Therapy	_____
Cell Therapy	_____	Supportive Care	
Chemoprevention	_____	_____	
Cytokines	_____	Surgery	_____
Developmental Chemotherapy	_____	Tumor Ablation Therapy	_____
Gene Therapy	_____	Vaccines	_____
Hemopoietic Stem Cell Transplantation	_____		
Hormone Therapy	_____	Other (specify)	
Immunotherapy	_____	_____	
Molecular Targeted Therapies	_____		

In addition to your interest in serving as an Oncology Research Program Investigator, are you interested in serving as an Expert Consultant to pharmaceutical/biotechnology companies?

Yes No

Directory Information

Are you active in any of the Cooperative Groups listed below? *(Check all that apply)*

ACOSOG American College of Surgeons Oncology Group _____
AMC AIDS Malignancy Consortium _____
CALGB Cancer & Leukemia Group _____
COG Children's Oncology Group _____
ECOG Eastern Cooperative Oncology Group _____
GOG Gynecologic Oncology Group _____
IRS Intergroup Rhabdomyosarcoma Study _____
NSABP National Surgical Adjuvant Project for Breast and Bowel Cancers _____
NABTT New Approaches to Brain Tumor Therapy _____
NCCTG North Central Cancer Treatment Group _____
PBTC Pediatric Brain Tumor Consortium _____
RTOG Radiation Therapy Oncology Group _____
SWOG Southwestern Oncology Group _____
Other _____ _____

Please provide the name(s) and contact information for the protocol nurse(s)/study coordinator(s) who covers your clinical trials:

Study Nurse:
Name, Title: _____
Phone: _____
E-Mail: _____
Pager: _____
Address: _____

Additional Study Staff:
Name, Title: _____
Phone: _____
E-Mail: _____
Pager: _____
Address: _____

I agree to be an investigator for the NCCN Oncology Research Program. I understand that this information will be part of the NCCN Investigator Database and will be used by NCCN to identify investigators for clinical trials. I understand that completion of this questionnaire does not guarantee my selection as an investigator by a pharmaceutical company. I acknowledge that NCCN makes no representations and shall not be held liable for use of this data by NCCN or for the accuracy of data entry by NCCN.

_____

Signature *Date*

Please return your completed forms to:

NCCN Directory
NCCN
500 Old York Road, Suite 250
Jenkintown, PA 19046
Fax: 215-690-0280