National Comprehensive Cancer Network Investigator Application

Name & Title:

Institution:

Street address:

City/State/Zipcode:

Business Phone:

Fax:

Email:

Listed below are several oncology specialties. Please indicate in which area you specialize and write in your subspecialty. In the second column, indicate whether this is your **Primary** or **Subspecialty** with a "P" or "S". Then indicate whether or not you are board certified in this specialty by entering a "Yes" or "No" in the third column.

SPECIALTY(IES)	P= PRIMARY SPECIALTY S= SUBSPECIALTY	BOARD CERTIFIED? Y/N
Medical Oncology		
Hematology/Oncology		
Surgery/Surgical Subspecialty *(Specify subspecialty)* _____ _____		
Radiation Oncology		
GYN Oncology		
Other *(Specify)* _____ _____		

Please indicate your areas of interest in the following aspects of oncology clinical trials.

CANCER SITE (*Check all that apply.)*

___ AIDS Related
___ Bone Cancer
___ Breast Cancer
___ Cervical Cancer
___ CNS Tumors
___ Colorectal Cancers
___ Endocrine Cancers
___ Genitourinary (specify) _____
___ GYN Cancers (specify) _____
___ Head & Neck
___ Leukemia
___ Lung cancers
___ Lymphoma
___ Myeloma
___ Other GI cancer (specify) _____
___ Other solid tumors (specify) _____
___ Pediatric Cancers (specify) _____
___ Prostate Cancer
___ Skin/Melanoma
___ Supportive Care/Quality of Life

STUDY PHASES *(Check all that apply.)*

Preclinical ___ Phase I___ Phase II___ Phase III___ Phase IV___

TREATMENT MODALITIES *(Check all that apply.)*

___ Cytokines
___ Gene Therapy
___ Immunotherapy
___ Developmental Chemotherapy
___ Radiation Therapy
___ Supportive care
___ Surgery
___ Vaccines
___ Pain
____ Other (specify)

In addition to your interest in serving as an investigator, are you interested in serving as an expert consultant to pharmaceutical/biotechnology companies? ☐ Yes ☐ No

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

___ AMC AIDS Malignancy Consortium
___ CALGB Cancer & Leukemia Group
___ CCG Children's Cancer 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
___ POG Pediatric Oncology Group
___ RTOG Radiation Therapy Oncology Group
___ SWOG Southwestern Oncology Group
___ OTHER _____

Please provide the name and contact information for the protocol nurse/study coordinator who covers your clinical trials.

Study Nurse _____
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 (ORP). 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, expert advisory committees, and research grants. 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 or for the accuracy of data entry by NCCN.

_____

Signature *Date*

Please attach a copy of your curriculum vitae and return via mail or fax to:

NCCN Oncology Research Program
500 Old York Road, Suite 250
Jenkintown, PA 19046
Fax: 215-690-0283