PORTEC-3 HOSPITAL REGISTRATION FORM

These data are required for administrative purposes. This form has to be completed by or on behalf of the local investigator for this study. Please send or fax to: IKW Trial office, C7-143, LUMC, P.O. Box 9600, 2300 RC Leiden, Fax +31(0)71-5266712

Date |___||___||_____| Signature local investigator: .....

Please fill out this form completely (names of persons) if you wish to participate in the PORTEC-3 trial. Patients from this center can only be included when the IKW Trial office has received this form. Any change in the specified functions must also be authorized by the local investigator with a revision of this form.

Hospital:
……
Location(s) *if applicable*:*
……
Postal address:
.....
Area code: **City:**
……

**If your center has more than one location, please fill out separate forms for each location. It must be clear which persons perform study-activities at which location. If a person performs study-activities at more than one location please fill out this name on both locations.*

Radiation oncologist (local investigator):
……
internal post address:
……
e-mail:
……
telephone: fax:
……
Coordinating medical oncologist:
……
Internal post address:
……
e-mail:
……
telephone: fax:
……
Local datamanagement:
……
e-mail:
……
Research nurse *if applicable***:**
……
e-mail:
……