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## **INVESTIGATOR ENROLLMENT AND DATABASE FORM**

Please complete and fax this form back to Exodon so we can finalize your adjunct appointment with Exodon. We appreciate your time and look forward to building your organization's clinical trial services.

*This information is strictly confidential and is not used for any purpose other than our internal investigator credentialing process and to perform a site feasibility analysis prior to delivering a study to you and your organization.*

### **Investigator/Researcher Information**

Investigator Name: \_\_\_\_\_

Title and Degree(s): \_\_\_\_\_

Investigator Mailing Address: \_\_\_\_\_

\_\_\_\_\_ (country) \_\_\_\_\_

Phone and Ext: \_\_\_\_\_ Fax: \_\_\_\_\_

E-mail: \_\_\_\_\_

Clinical Specialty: \_\_\_\_\_ Board Certified:  Yes  No

Subspecialty: \_\_\_\_\_ Board Certified:  Yes  No

Best Days/Times To Reach Investigator: Day(s) of Week \_\_\_\_\_ Time(s) \_\_\_\_\_

Clinical Research Specialty: (e.g., Stroke, Dementia, Pain, etc.)

1. \_\_\_\_\_ Avg. # of previous studies \_\_\_\_\_

2. \_\_\_\_\_ Avg. # of previous studies \_\_\_\_\_

3. \_\_\_\_\_ Avg. # of previous studies \_\_\_\_\_

4. \_\_\_\_\_ Avg. # of previous studies \_\_\_\_\_

5. \_\_\_\_\_ Avg. # of previous studies \_\_\_\_\_

6. \_\_\_\_\_ Avg. # of previous studies \_\_\_\_\_

How many of these studies were you the Principal Investigator? \_\_\_\_\_.

Which type of clinical trials do you prefer? Phases:  I  II  III  IV

List the clinical research rating scales, tests, inventories, etc. that you consider yourself to be well trained and experienced to administer (e.g., the Brief Psychiatric Rating Scale, the Unified Parkinson's Disease Rating Scale, etc.) \_\_\_\_\_

<b>To be completed by Investigator only</b>	
These questions need to be answered by the researcher/clinician only. Please circle your response.	
1. After reviewing a study protocol, how much time do you think you will need to decide if you want to participate in a study? a. 1 hour or less d. 2-3 days b. 2-24 hours e. Greater than 4 days c. More than 1 day	4. How important is it for your site to be able to compete against other clinical research sites? a. Very Important b. Moderately Important c. Not very Important
2. What is your tolerance level for making decisions that might have large negative consequences? a. Very tolerant b. Moderately tolerant c. Not very tolerant	5. How important is it to move beyond the status quo and develop a cutting edge clinical research practice? a. Very Important b. Moderately Important c. Not Very Important
3. Do you prefer to be a Principal Investigator on studies? a. As often as possible b. At least half of the time c. Doesn't matter	6. When making decisions, how important is it getting the project completed versus being sure you are correct?? a. Very Important b. Moderately Important c. Not Very Important
7. How would you rate your level of Persistence? a. Very Persistent b. Moderately Persistent c. Not Very Persistent	10. When working on a research hypothesis how much do you value lively and spirited interaction from others? a. Very Much b. Moderately c. Not Very Much
8. When making important decisions, how worried do you typically get? a. Very Worried b. Moderately Worried c. Not Very Worried	11. When working on a research hypothesis how much do you value facts over theory? a. Very Much b. Moderately c. Not Very Much
9. How absorbed do you become in a single clinical research study? a. Very absorbed b. Moderately absorbed c. Not very absorbed	12. How important is saving money when conducting research? a. Very Important b. Moderately Important c. Not Very Important

**Site/Practice Information**

Primary Contact at your practice/site: Name: \_\_\_\_\_

E-mail: \_\_\_\_\_

Phone Number and extension: \_\_\_\_\_

Please indicate what type of medical record system you use in your practice:

Paper       Word       eCast EMR       Other EMR

\_\_\_\_\_

Medical Records Coordinator Name: \_\_\_\_\_

E-mail: \_\_\_\_\_

Phone Number and extension: \_\_\_\_\_

Do you have a clinical research coordinator on site:    Yes      No

Research Coordinator Name: \_\_\_\_\_

E-mail: \_\_\_\_\_

Phone Number and extension: \_\_\_\_\_

# previous trials \_\_\_\_\_

If you do not have an experienced research coordinator available, Exodon will provide one. For more information check here

Type of Practice(s):  Solo  Group  Multi-Specialty  VA  Research Only  University  Hospital  
 Other \_\_\_\_\_

If necessary would you be able to admit or arrange for admission of a clinical trial patient at hospital that would allow that patient to continue participating in the clinical trial. Yes No  If yes – please enter the name(s) of the hospital \_\_\_\_\_

Average number of **monthly** patients you treat from all clinical research sites listed above \_\_\_\_\_

Please assign a percentage to this monthly average of patients from the following categories:

- Affective Disorders \_\_\_\_\_ %
- Autoimmune Disorder \_\_\_\_\_ %
- Brain Tumors \_\_\_\_\_ %
- Cardiovascular Disorders \_\_\_\_\_ %
- Cerebrovascular Disorders \_\_\_\_\_ %
- CNS Infectious Disorders \_\_\_\_\_ %
- Cognitive Impairment and Dementia \_\_\_\_\_ %
- Eating Disorders \_\_\_\_\_ %
- Endocrinology Related Conditions \_\_\_\_\_ %
- Gastroenterology Related Disorders \_\_\_\_\_ %
- Headaches/Pain \_\_\_\_\_ %
- Hematological Conditions \_\_\_\_\_ %
- Immunological and non-CNS Infectious Related Disorders \_\_\_\_\_ %
- Movement Disorders \_\_\_\_\_ %
- Multiple Sclerosis \_\_\_\_\_ %
- Musculoskeletal Related Disorders \_\_\_\_\_ %
- Nephrology and Urological Disorders \_\_\_\_\_ %
- Neurodevelopmental Disorders \_\_\_\_\_ %
- Neurodiagnostics/Neurophysiology Studies \_\_\_\_\_ %
- Neuroendocrine \_\_\_\_\_ %
- Neurogenomics/Neurogenetics \_\_\_\_\_ %
- Neuromuscular Disorders \_\_\_\_\_ %
- Neuropsychiatric Disorders \_\_\_\_\_ %
- Obstetrics and Gynecology Related Disorders \_\_\_\_\_ %
- Oncology non-CNS Related Disorders \_\_\_\_\_ %
- Ophthalmologic Diseases \_\_\_\_\_ %
- Otolaryngology \_\_\_\_\_ %
- Personality Disorder \_\_\_\_\_ %
- Pulmonary and Respiratory Diseases \_\_\_\_\_ %
- Rheumatology Related Disorders \_\_\_\_\_ %
- Seizures/Epilepsy \_\_\_\_\_ %
- Sleep Disorders \_\_\_\_\_ %
- Substance Abuse/Addiction \_\_\_\_\_ %
- Traumatic Brain and Spinal Cord Injury \_\_\_\_\_ %

Please estimate race, age and gender percentages of patients/subjects:

Caucasian _____ %	0-11 _____ %	Female _____ %
African-American _____ %	12-18 _____ %	Male _____ %
Asian _____ %	19-39 _____ %	
Hispanic _____ %	40-59 _____ %	
Other _____ %	> 60 _____ %	

What percentage of your patients are outpatients \_\_\_\_\_ %

What percentage of your patients are inpatients \_\_\_\_\_ %

Indicate the percentage of patients that will need to go through an internal or institutional IRB in addition to the study's IRB \_\_\_\_\_ %

If your site requires and internal IRB, on average how many days lapse from the date of IRB submission to the IRB response \_\_\_\_\_

Please enter the name of IRB(s) used by you or your group \_\_\_\_\_

On average, how long does it take you or your group to accept and sign a clinical research contract from the time you receive the initial protocol \_\_\_\_\_

Have you or your group received an FDA 483. If yes, describe outcome \_\_\_\_\_

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**Facility Information**

Please indicate the name of each of your sites where you consult and treat patients:

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

Please indicate if you have daily access to:

Pharmacy  Yes  No

Clinical Lab  Yes  No

Phlebotomy  Yes  No

For site #(s) \_\_\_\_\_

For site # (s) \_\_\_\_\_

For site #(s) \_\_\_\_\_

Freezer:  -20 to -70  -70 or below

Centrifuge Available  Yes  No

Radiology  Yes  No

For site #(s) \_\_\_\_\_

For site #(s) \_\_\_\_\_

For site #(s) \_\_\_\_\_

Secure Drug Storage  Yes  No  
equipment

Neuropsych Testing  Yes  No

Types of Neuroimaging

For site #(s) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Additional Equipment**

Internet connections: dial-up For site #(s) \_\_\_\_\_ broad band For site #(s) \_\_\_\_\_

Current Scanner(s) Enter Brand, Model # and if it has an Automatic Document Feeder For site #(s) \_\_\_\_\_

Current Printer(s) Enter Brand, Model # and if it has an Automatic Document Feeder For site #(s) \_\_\_\_\_

Computer connected to scanner(s) Enter Brand, Model # and operating system For site #(s) \_\_\_\_\_

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Please submit this form and attach the investigator's CV and Exodon's Non-disclosure agreement. Our office will contact you within 1-2 days and start your credentialing process as an investigator in Exodon's VALIDATE System® network of international clinical research sites. We greatly look forward working with you.