

Quarterly Trial Verification Form

Patient Name: _____ **Date:** _____

THIS SECTION BELOW MUST BE COMPLETED BY YOUR MEDICAL REPRESENTATIVE ONLY
(Oncologist, nurse, doctor, social worker or clinical trial coordinator, etc.)

Clinical Trial Doctor: _____

Clinical Trial Clinic/Hospital: _____

Clinical Trial Address: _____

City, State, Zip: _____

Phone Number: _____ **Email Address:** _____

Clinical Trial Sponsor Company: _____

Clinical Trial Name: _____
NCT # _____
(Required for assistance)

Phase of Clinical Trial: Phase 1 Phase 2 Phase 3 Phase 4

Is patient currently receiving financial reimbursement from clinical trial? Yes No

Treatment Schedule: _____
(EX: 3 weeks on 3 weeks off)

If yes, what type? _____

NAME AND TITLE OF MEDICAL REPRESENTATIVE COMPLETING THIS SECTION, IF DIFFERENT THAN ABOVE: (please print clearly)

Name: _____ **Title:** _____

Direct Phone Number: (no general #s) _____ **Email Address:** _____

I verify that (patient) _____ **is still currently enrolled in the above clinical trial.**

Signature of Medical Representative: _____ **Date:** _____

Your relationship to person applying for help: Doctor Nurse Social Worker CT Coordinator Other: _____

Fax this form to 925-552-7305 or email to Ronna@lazarex.org or mail to Lazarex Cancer Foundation, P. O. Box 741, Danville, CA 94526.