

## **Quarterly Trial Verification Form**

Patient Name:	Date:		
<u>TH</u>	S SECTION BELOW MUST BE COMPLETED BY YOUR MEDICA (Oncologist, nurse, doctor, social worker or clinical trial		
Clinical Trial Doctor:			
Clinical Trial Clinic/Hospita	al:		
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 Ves reimbursement from clinical trial? 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 <u>Ronna@lazarex.org</u>	or mail to Lazarex Cancer Foundation, P. O. Box 741, Danville, CA 94526.

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