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**PAREXEL International is a proven and committed partner to drug developers and medical device manufacturers looking to bring innovative new products to market.**

*If there is more than one Investigator at your site that would like to be considered for clinical research, you must complete a profile for each Investigator.*

**I would like to participate in clinical research studies with PAREXEL International and I agree to be contacted by PAREXEL International via email or other means with clinical research opportunities.**

- Yes, I give my permission for PAREXEL International to contact me for participation in clinical research studies.
- No, I do not give my permission for PAREXEL International to contact me for participation in clinical research studies.

**By submission of this information, on behalf of the site, I consent to the use of this data by PAREXEL and its affiliated companies for site selection, administrative purposes, and any other purpose required by law.**

COMPLETED BY:

Last name: \_\_\_\_\_

First name: \_\_\_\_\_

**What is your primary role at this site?**

- Principal Investigator       Study Nurse
- Sub-Investigator           Study Coordinator

Other (please specify):

**Investigator Name:**

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_

Middle Initial: \_\_\_\_\_

**Degree:**

- |    |                          |     |                          |     |                          |     |                          |
|----|--------------------------|-----|--------------------------|-----|--------------------------|-----|--------------------------|
| DO | <input type="checkbox"/> | RPH | <input type="checkbox"/> | MPH | <input type="checkbox"/> | MSN | <input type="checkbox"/> |
| MD | <input type="checkbox"/> | MS  | <input type="checkbox"/> | PHD | <input type="checkbox"/> | MBA | <input type="checkbox"/> |

**Title/Greeting:**

- Dr  Professor  Miss  Sir  Ms.  Mr.  Other:

**Please provide the address where you wish to be contacted with potential opportunities.**

Office Name: \_\_\_\_\_  
Address Line 1: \_\_\_\_\_  
Address Line 2: \_\_\_\_\_  
City: \_\_\_\_\_  
State/Province: \_\_\_\_\_  
Postal Code: \_\_\_\_\_  
Country: \_\_\_\_\_  
Office Phone: \_\_\_\_\_  
Fax Number: \_\_\_\_\_  
Email: \_\_\_\_\_

**Please select any of following Therapeutic Areas for which you have experience and/or interest.**

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Allergy & Immunology | <input type="checkbox"/> Gastroenterology   | <input type="checkbox"/> Nephrology     | <input type="checkbox"/> Psychiatry       |
| <input type="checkbox"/> Anesthesia           | <input type="checkbox"/> Genetics           | <input type="checkbox"/> Neurology      | <input type="checkbox"/> Pulmonology      |
| <input type="checkbox"/> Cardiology           | <input type="checkbox"/> Genitourinary      | <input type="checkbox"/> Obstetrics/GYN | <input type="checkbox"/> Radiology        |
| <input type="checkbox"/> Dentistry            | <input type="checkbox"/> Gerontology        | <input type="checkbox"/> Oncology       | <input type="checkbox"/> Rheumatology     |
| <input type="checkbox"/> Dermatology          | <input type="checkbox"/> Hematology         | <input type="checkbox"/> Ophthalmology  | <input type="checkbox"/> Surgery          |
| <input type="checkbox"/> Emergency Medicine   | <input type="checkbox"/> Infectious Disease | <input type="checkbox"/> Orthopedics    | <input type="checkbox"/> Transplant       |
| <input type="checkbox"/> Endocrine/Metabolism | <input type="checkbox"/> Intensive Care     | <input type="checkbox"/> Otolaryngology | <input type="checkbox"/> Vascular Disease |
| <input type="checkbox"/> Epidemiology         | <input type="checkbox"/> Internal Medicine  | <input type="checkbox"/> Pediatrics     | <input type="checkbox"/> Veterinary       |

**Please list the Indications in which you have clinical trial experience and/or interest:**

Indication 1 _____	Number of Trials Participated in: _____
Indication 2 _____	Number of Trials Participated in: _____
Indication 3 _____	Number of Trials Participated in: _____
Indication 4 _____	Number of Trials Participated in: _____
Indication 5 _____	Number of Trials Participated in: _____
Indication 6 _____	Number of Trials Participated in: _____
Indication 7 _____	Number of Trials Participated in: _____

**What age group(s) does your site see?**

- Neonatal       Pediatric       Geriatric       Adolescent       Adult

**Investigator clinical research experience:**

I have been involved in Clinical Research since: \_\_\_\_\_

**Total number of trials you have conducted as a Principal Investigator:**

- |                                |                                 |                                  |                                  |
|--------------------------------|---------------------------------|----------------------------------|----------------------------------|
| <input type="checkbox"/> 0     | <input type="checkbox"/> 4 - 6  | <input type="checkbox"/> 11 - 15 | <input type="checkbox"/> 21 - 25 |
| <input type="checkbox"/> 1 - 3 | <input type="checkbox"/> 7 - 10 | <input type="checkbox"/> 16 - 20 | <input type="checkbox"/> >25     |

**Total number of trials you have conducted as a Principal Investigator by Phase:**

Phase I \_\_\_\_\_ Phase II \_\_\_\_\_ Phase III \_\_\_\_\_ Phase IV \_\_\_\_\_

**Amount of time you devote to Clinical Research per week as Principal Investigator:**

- < 10 hrs     10 hrs - 30 hrs     >30 hrs

**Does your site have the ability to conduct Electronic Data Capture (EDC) trials?**

Yes       No

**Does your site have experience with Electronic Data Capture (EDC) studies?**

Yes       No

**Is the Investigator fluent in English?**

Yes       No

**Does your site conduct research through a Site Management Organization or Network?**

Yes       No

**Site Management Organization (SMO) or Network through which research is conducted:**

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

Acronym: \_\_\_\_\_

Phone: \_\_\_\_\_

**Should Investigator first contact be made via SMO?**

Yes       No

**Do you have a Research Study Coordinator(s)?**

Yes       No

**Is your Study Coordinator(s) fluent in English?**

Yes       No      Additional comments:

**How many Study Coordinators conduct research at your site? \***

**Primary Study Coordinator Information:**

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_

Title/Degree: \_\_\_\_\_

Office Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Email Address: \_\_\_\_\_

**What percentage of your Study Coordinators' time is dedicated to research?**

0%       25%       50%       75%       100%

**Study Coordinator clinical research experience:**

0 years       1-2 years       3-5 years       >5 years

**Complete the following information for the HOSPITAL where an INPATIENT study would be conducted:**

Hospital Name: \_\_\_\_\_

Main Phone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

Email: \_\_\_\_\_

City: \_\_\_\_\_

State/Province: \_\_\_\_\_

**Type of hospital - check one:**

- |  |   |
|--|---|
| <input type="checkbox"/> Community Medical Center  | <input type="checkbox"/> Public Health /Military/Veteran's Hospital |
| <input type="checkbox"/> Dedicated Research Center | <input type="checkbox"/> Rehabilitation Center                      |
| <input type="checkbox"/> General Hospital          | <input type="checkbox"/> University Hospital/Medical Center         |
| <input type="checkbox"/> Private Hospital          |   |

**What type of IRB/EC is your site able to use?**

- Local     Central (Independent from your site, example WIRB)     Both Central and Local

**Local IRB/EC name:** \_\_\_\_\_

**Frequency of meetings:**

- |                                    |                                     |                                    |
|------------------------------------|-------------------------------------|------------------------------------|
| <input type="checkbox"/> Weekly    | <input type="checkbox"/> Bi-Weekly  | <input type="checkbox"/> Monthly   |
| <input type="checkbox"/> Quarterly | <input type="checkbox"/> Bi-Monthly | <input type="checkbox"/> As needed |

**Average time from IRB/EC submission to IRB/EC approval:**

- Less than 1 month     1-2 months     More than 2 months

**How long in advance of the meeting should the documents be submitted for evaluation?**

**Practice/Research OrganizationName:**

\_\_\_\_\_

**Please check all that apply to your Practice/Research Organization:**

- |   |  |
|---|--|
| <input type="checkbox"/> Clinic                                 | <input type="checkbox"/> Research Organization |
| <input type="checkbox"/> Clinical Trial Management Organization | <input type="checkbox"/> Group Practice        |
| <input type="checkbox"/> Multi-speciality                       | <input type="checkbox"/> Primary Care Center   |
| <input type="checkbox"/> Private Practice                       | <input type="checkbox"/> Research Center       |
| <input type="checkbox"/> Other (please specify) _____           |  |

**Number of physicians in the Practice:** \_\_\_\_\_

**Number of investigators in the Practice:** \_\_\_\_\_

**What type of trials are you interested in conducting? (check all that apply):**

- Outpatient trials     Inpatient trials

**Please feel free to provide any further comments about your site or interests that you feel might be helpful.**

***Thank You* for completing your profile.**