Profile Checklist for the *Investigator* Registration Type

Asterisk (*) denotes that the section is mandatory for NCI registration.

Note that this checklist provides the requirements to complete one record within a document section (i.e., the Education section of the NCI Biosketch includes 6 pieces of information to complete one education record). When entering information in RCR, it is expected that you will enter multiple records per section, as needed, to provide a complete record of your credentials. For example, in the Education section, you will enter one record for each degree you've achieved since graduating high school.

Primary Contact Information*

This information includes your Primary Organization (the location where mail is delivered to you), address, phone, and email and is automatically populated from your IAM account.

Form FDA 1572*

*Practice Sites**

Notes: Multiple sites can be entered; entry of the CTEP Site Code populates all required fields.

CTEP Site Code:

Site Name:

*Labs**

Notes: Multiple labs can be entered; US Labs use CLIA or CAP IDs; Entry of the Lab ID auto-populates all required fields.

Lab ID:

Lab Name:

Lab Certification (*Requires upload of a scanned certification only if the lab cannot be selected from the RCR list of values.*)

*IRBs**

Notes: Multiple IRBs can be entered; entry of the IRB Number populates all required fields.

IRB Number (OHRP):

IRB Name:

NCI Biosketch*

*Personal Information**

Prefix (*Mr., Ms., Dr., Mrs., etc.*):

First Name:

Middle Name or Initial:

Last Name:

Suffix (*Jr., Sr., II, III, etc.*):

Date of Birth (*Month and Year*):

Signature Display (*How your name is displayed on electronically signed documents.*):

Correspondence Display (*How your name is displayed on email and notifications.*):

*Education**

☐ This section is mandatory for NCI registration, but you may select this checkbox to indicate that this section does not apply to you.

Country (*If other than US.*):

Degree:

Field of Study:

Institution:

Location:

Completion Date:

*Professional Training**

☐ This section is mandatory for NCI registration, but you may select this checkbox to indicate that this section does not apply to you.

Country (*If other than US.*):

From Year:

To Year:

Position (*Intern, Resident, Fellow*):

Institution:

Location:

*Employment**

☐ This section is mandatory for NCI registration, but you may select this checkbox to indicate that this section does not apply to you.

Country (*If other than US.*):

From Year:

To Year:

Position:

Institution:

Location:

*Professional Certification**

☐ This section is mandatory for NCI registration, but you may select this checkbox to indicate that this section does not apply to you.

Country (*If other than US.*):

Certification Title:

Certification Provider:

Effective Date:

Expiration Date:

*Professional License**

☐ This section is mandatory for NCI registration, but you may select this checkbox to indicate that this section does not apply to you.

Country (*If other than US.*):

License Type:

State/Province:

License Number:

Expiration Date:

*ABMS Board Certification**

☐ This section is mandatory for NCI registration, but you may select this checkbox to indicate that this section does not apply to you.

Specialty:

Sub-Specialty:

Board Eligible / Certified:

Effective Date:

Expiration Date:

*NCI Required Training**

Good Clinical Practice (GCP) and Human Subject Protection (HSP) Training is required for all persons participating on NCI-sponsored studies.

Country (GCP) (*If other than US.*):

Course Type (GCP):
Training Provider (GCP):
Completion Date (GCP):
Expiration Date (GCP):
Certificate (GCP) (*Requires upload of scanned copy.*)
Country (HSP) (*If other than US.*):
Course Type (HSP):
Training Provider (HSP):
Completion Date (HSP):
Expiration Date (HSP) *(If a non-NIH provided training is used, the training provider may have an expiration date.)*
Certificate (HSP) (*Requires upload of scanned copy.*)

Optional Biosketch Information

Curriculum Vitae (*Optional upload of scanned copy.*)
Personal Statement:
Professional Memberships:
Professional Honors:
Publications (*Relevant to current application.*):
Additional Publications:
Research Support (*Completed/Ongoing*):

Financial Disclosure Form (FDF)*

The Financial Disclosure Form includes four yes or no questions. The pharmaceutical company name must be provided when 'Yes' is selected for any question included on the form.

Agent Shipment Form*

This section is required only if CTEP-supplied agents will be ordered by you or on your behalf and shipped to your practice site.

Practice Site CTEP Site Code:
Practice Site Name:
Shipping Designee CTEP Person ID:
Shipping Designee Name:
Shipping Designee Address:
Shipping Designee Contact Information (*Phone and Email*):
Ordering Designee CTEP Person ID:
Ordering Designee Name:
Ordering Designee Contact Information (*Phone and Email*):

Practice Preferences

Medical/Professional Specialty:
Areas of Interest:
Primary Practice Type: