

ABBREVIATED CURRICULUM VITAE



Name:

Professional Title:

Organization:

Address1:

Address2:

E-Mail:

Main Daytime Phone:

Pager:

Mobile Phone:

24 Hour Phone:

Evening Phone:

Fax:

AFFILIATIONS

| Facility Name | Department Name | Facility/Department Address |
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EDUCATION

| University/School/Program | Degree/Certificate | Specialty | Year Completed |
|---------------------------|--------------------|-----------|----------------|
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PROFESSIONAL EXPERIENCE

| Job Title | Institution | Year Started | Year Completed |
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LICENSE DETAILS

| Type of License | If Other, Type of License | License Issuer | Professional License Number | Country | State, Province or Region | Expiration Date |
|-----------------|---------------------------|----------------|-----------------------------|---------|---------------------------|-----------------|
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Name: _____ Main Daytime Phone: _____
 Professional Title: _____ Pager: _____
 Organization: _____ Mobile Phone: _____
 Address1: _____ 24 Hour Phone: _____
 Address2: _____ Evening Phone: _____
 E-Mail: _____ Fax: _____

RESEARCH EXPERIENCE

Study Type (Check all that apply):

- Academic Industry
- Investigator-Initiated Government
- Other / Please specify: _____

Clinical Study Phases (Check all that apply): I II III IV

Therapeutic Areas of Expertise:

| Therapeutic Area | Sub-Therapeutic Area |
|------------------|----------------------|
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Total Clinical Research Experience:

| Therapeutic Area | Sub-Therapeutic Area | Number of completed studies | Number of ongoing studies |
|------------------|----------------------|-----------------------------|---------------------------|
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Good Clinical Practice (GCP) Training Details:

| Training Provider | Title of Training | Version | Date Completed | Status |
|-------------------|-------------------|---------|----------------|--------|
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By signing this form, I confirm that the information provided on this Abbreviated CV is accurate and reflects my current employment and qualifications:

Signature: _____ **Date:** _____