

**Participating Institutions/Practices Application**

**Please return the completed Application to** **GOGPartnersmembership@gog.org****. Should you have any questions, please contact Tivona LeMar, Membership Manager, by telephone at 215-854-0770 or via e-mail at** **tlemar@gog.org****.**

*ALL SECTIONS MUST BE COMPLETED BY APPLICANT INSTITUTION*

 **GOG FOUNDATION PARTICIPATING INSTITUTION/PRACTICE APPLICATION**

Please complete all sections of this application. The completed application will be reviewed by the GOG Foundation Quality Assessment Committee. Incomplete applications will delay participation approval.

**Name of Institution:**

**Name of Principal Investigator for this applicant Institution:**

**Address:**

**City:**

**State:**

**Zip:**

**Phone:**

**Fax:**

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**Federal wide Assurance # for the applicant institution:**

*Verification of FWA Coverage is required prior to membership activation*

**GOG FOUNDATION PARTICIPATION APPLICATION**

**INSTITUTION/PRACTICE:**

1. Will you assign a data manager to be responsible for submission of required data?

Yes [ ]  No [ ]

If no, who will be responsible for the data management?

1. Will you provide this individual with the necessary administrative support to assure that data required from all departments is submitted on time?

Yes [ ]  No [ ]

1. Will you continue to submit patient follow-up data in the event your institution should withdraw or be terminated from the GOG Foundation or the proposed Principal Investigator should leave your institution?

Yes [ ]  No [ ]

1. Will you have the support to do the necessary regulatory work for study start up, ongoing regulatory support, and Institutional Review Board approvals?

Yes [ ]  No [ ]

1. Do you have Institutional and Departmental support for your participation in the GOG Foundation?

Yes [ ]  No [ ]

1. Has the applicant Institution/practice and/or its Principal Investigator previously participated in Industry sponsored gynecologic oncology clinical trials?

Yes [ ]  No [ ]

1. Does your institution/practice have access to an investigational pharmacy or the capability to adequately handle investigational drugs?

Yes [ ]  No [ ]

1. Does your institution/practice have the capability to submit forms electronically?

Yes [ ]  No [ ]

1. Do you have a designated Pathologist to work with the GOG Foundation who is able to submit tumor blocks, slides, and pathology reports/forms as required?

Yes [ ]  No [ ]

1. Has the FDA or equivalent regulatory agency ever inspected your site?

Yes [ ]  No [ ]

If yes, please attach all report findings and your response.

Comment:

1. Are investigators required to complete Good Clinical Practice training?

 Yes [ ]  No [ ]

If yes, how often is training required? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Are investigators required to complete Human Subject Protection Training?

Yes [ ]  No [ ]

If yes, how often is the training required? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. If you answered NO to any of the above (except Question 10), please explain below:

**PLEASE ATTACH THE FOLLOWING AS ELECTRONIC DOCUMENTS**:

*Letters must be submitted on Institution/Practice letterhead*

1. A letter of intent to participate in the GOG Foundation from the departmental contact for each specialty that is planning to actively participate in the GOG Foundation.
2. GYN Oncology OR Medical Oncology (REQUIRED)
3. Pathology (PREFERABLE)
4. Radiation Oncology (If applicable)
5. A letter from the Department Chair/Director of Research of the Institution indicating the Institution’s approval and support for participation in the GOG Foundation and its protocols. If private practice – letter of support from practice signatory official.
6. Letter detailing previous clinical trial experience (Industry, Cooperative Group, Investigator Initiated).
7. Bio sketch of Applicant Principal Investigator

**PLEASE PROVIDE CONTACT INFORMATION FOR CONTRACTS REPRESENTATIVE**

NAME:

Address:

City: State: Zip Code:

Phone: Fax: E-Mail:

**PLEASE PROVIDE CONTACT INFORMATION FOR PAYMENTS**

NAME:

Address:

City: State: Zip Code

Phone: Fax: E-Mail:

**INSTITUTION:**

**Key Personnel who will participate in the GOG Foundation -**  List names, address, telephone, fax and email addresses of the key personnel at your Institution who will be responsible for GOG Foundation activities (e.g., Principal Investigator, Sub-Investigators, Data Managers, Nurses, CRA’s, Regulatory Managers)

Name:

Degree:

Specialty:

Address:

City:

State:

Zip Code:

Phone:

Fax:

E-mail:

Name:

Degree:

Specialty:

Address:

City:

State:

Zip Code:

Phone:

Fax:

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Phone:

Fax:

E-mail:

Name:

Degree:

Specialty:

Address:

City:

State:

Zip Code:

Phone:

Fax:

E-mail:

Name:

Degree:

Specialty:

Address:

City:

State:

Zip Code:

Phone:

Fax:

E-mail: