

National Institutes of Health  
National Cancer Institute

Division of Cancer Treatment and Diagnosis  
Cancer Therapy Evaluation Program

Address: (Including Institution Name)

**FOR NCI USE ONLY**

**Return Drug List**

***Return only agents supplied by:***  
***CTEP, DCTD, National Cancer Institute***

Return. No.:

Signature of Authorizing Official:

The agents listed below were ordered by (one investigator per form only):

**Dr.**

Date of Authorization:

**CTEP Investigator ID:**

**Fill in e-mail address below to receive return receipt.**

NSC Number	Agent Name	NCI Protocol Number	Strength & Formulation (Specify vials, capsules, or tablets)	Lot Number (or Patient ID for Blinded Trial)	Manufacturer	Quantity (Specify whole or partial containers)	Container Number	Action
1								
Reason for return: <input type="checkbox"/> Lot expired <input type="checkbox"/> Protocol closed/complete <input type="checkbox"/> IND withdrawn/inactivated <input type="checkbox"/> Patient cross over <input type="checkbox"/> Patient expired/went off treatment <input type="checkbox"/> Unsuitable								
2								
Reason for return: <input type="checkbox"/> Lot expired <input type="checkbox"/> Protocol closed/complete <input type="checkbox"/> IND withdrawn/inactivated <input type="checkbox"/> Patient cross over <input type="checkbox"/> Patient expired/went off treatment <input type="checkbox"/> Unsuitable								
3								
Reason for return: <input type="checkbox"/> Lot expired <input type="checkbox"/> Protocol closed/complete <input type="checkbox"/> IND withdrawn/inactivated <input type="checkbox"/> Patient cross over <input type="checkbox"/> Patient expired/went off treatment <input type="checkbox"/> Unsuitable								
4								
Reason for return: <input type="checkbox"/> Lot expired <input type="checkbox"/> Protocol closed/complete <input type="checkbox"/> IND withdrawn/inactivated <input type="checkbox"/> Patient cross over <input type="checkbox"/> Patient expired/went off treatment <input type="checkbox"/> Unsuitable								

**REPOSITORY COMMENTS**

Date Received:

**INSTRUCTIONS:**

1. Properly complete all sections to receive credit for the return.
2. Type all information-one item, lot, or protocol per line.
3. DO NOT mark in shaded areas.
4. Investigator signature or signature of individual preparing this form:
5. Pack the agent(s) well to minimize breakage and leakage.
6. All agents may be returned via room temperature
7. Enclose the completed list with the agent(s) and return to:

✂  
 NCI Clinical Repository  
 4650 New Design Road, Suite D  
 Frederick, MD 21703  
 Attn: Returns

**RETURN RECEIPT:** To obtain a return receipt by e-mail, provide your e-mail address in the space below.

Signature / Printed Name

Date

Title

Phone No.

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