Profile Checklist for the *Non-Physician 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.

Provider No:*

Lab Name:*

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 Year:*

*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 (*Month and Year*):*

Expiration Date (*Month and Year*):*

*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 (*Month and Year*):*

Upload License (**Mandatory only if license is from a country outside of US*.)

Comments (**Mandatory only if cannot be system validated or if Expiration Date is in the past.*)

*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 (*Month and Year*):*

Expiration Date (*Month and Year*):*

*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
Course Title (GCP):*
Training Provider (GCP):*
Completion Date (GCP) (*Month and Year*):*
Expiration Date (GCP) (*Month and Year*):*
Certificate (GCP) (*Requires upload of scanned copy.*):*
Country (HSP) (*If other than US.*):*
Course Type: HSP
Course Title (HSP):*
Training Provider (HSP):*
Completion Date (HSP) (*Month and Year*):*
Expiration Date (HSP) (*Month and Year; 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.

Practice Preferences

Medical/Professional Specialty:
Areas of Interest: