SIOPEL Registry

PARTICIPATION FORM

Please complete the following steps:

1) fill in the form
2) print the completed form and collect signatures
3) fax the form with the signatures to SIOPEL Data Center
   For UK: +44 121 414 9520
   International: +44 207 813 85 88

*Participating Request for the Study:	

We agree to:

- ☐ comply with the protocol requirements
- ☐ provide the necessary information through the CINECA remote data entry system for central review in a timely manner
- ☐ obtain the necessary ethical and regulatory approval required by our country prior to entry the first patient, and supply a copy to the SIOPEL data center in the UK, if not uploaded in this participating form

Upload scanned signed documents or fax a copy to SIOPEL Data Center:	**Signed Form of Participation (this form)** ☐ fax **Institutional Review Board (IRB) or Ethics Committee (EC) approval** ☐ fax or Upload Date of approval: dd mm yyyy **Health Authority and/or other applicable approval as required by national regulations** ☐ fax or Upload Date of approval: dd mm yyyy

Participating Center:	
* Hospital/Institution name:	
* Department name:	
* Address:	
* Zip Code:	
* City:	
* Country:	
* Telephone:	
* FAX:	
*** Responsible Physician:**	
* Surname:	
* Forename:	
Clinician address (if different from above):	
* Clinician Telephone:	
* Clinician E-mail:	
Signature:	
Signature Date:	dd mm yyyy
Please fill in data:	
☐ Responsible Radiologist	
* Surname	
* Forename:	
* Telephone:	
* E-mail:	
Signature:	
Signature Date:	dd mm yyyy
☐ Responsible Surgeon	
* Surname:	
* Forename:	
* Telephone:	
* E-mail:	
Signature:	
Signature Date:	dd mm yyyy

☐ Responsible Pathologist	
* Surname:	
* Forename:	
* Telephone:	
* E-mail:	
Signature:	
Signature Date:	dd mm yyyy
☐ Responsible Consultant Audiologist or ENT Surgeon (specify which)	
* Surname:	
* Forename:	
* Telephone:	
* E-mail:	
	○ Consultant Audiologist ○ ENT Surgeon
Signature:	
Signature Date:	dd mm yyyy
☐ Responsible Data Manager	
* Surname:	
* Forename:	
* Telephone:	
* E-mail:	
Signature:	
Signature Date:	dd mm yyyy
☐ Responsible Pharmacist	
* Surname	
* Forename:	
* Telephone:	
* E-mail:	
Signature:	
Signature Date:	

	dd mm yyyy

LABORATORY (complete for SIOPEL 4 and SIOPEL 5 only):

* Laboratory Name	

Units and range*:

		Range*	
Test	**Unit***	**Min**	**Max**
Haemoglobin			
White Blood Cells Count			
Neutrophilis			
Platelets			
AFP			
Beta HCG			

Previously Registered for RDE system:

Do you already have an USERID for the RDE system:	
If yes, please enter your USERID :	