

Membership Application

General Information

Official NCI Roster Name _____

Site NCI Number _____

Membership Type CCOP Minority-Based CCOP Main Member

CCOP Grant Number _____

Federal Wide Assurance Number _____

FWA Expiration Date _____

Components

Name _____

Address _____

City _____ State _____ Zip _____

NCI Number _____ Assurance Number _____
(If not covered under primary FWA)

Name _____

Address _____

City _____ State _____ Zip _____

NCI Number _____ Assurance Number _____
(If not covered under primary FWA)

Name _____

Address _____

City _____ State _____ Zip _____

NCI Number _____ Assurance Number _____
(If not covered under primary FWA)

Institutional Review Boards

Name _____	_____	Affiliated Components Covered

Name _____	_____	_____

Name _____	_____	_____

Membership Application

Primary Contact Information

Principal Investigator

NCI Number _____

Name (First, Middle, Last) _____ Credentials _____

Title at Site _____ Specialty _____

Phone Number () _____ Fax () _____

E-mail Address _____

Mailing Address _____

City _____ State _____ Zip _____

Administrator

Name (First, Middle, Last) _____ Credentials _____

Title at Site _____ Role at Site _____

Phone Number () _____ Fax () _____

E-mail Address _____

Mailing Address _____

City _____ State _____ Zip _____

Additional Staff

Name (First, Middle, Last) _____ Credentials _____

Title at Site _____ Role at Site _____

Phone Number () _____ Fax () _____

E-mail Address _____

Mailing Address _____

City _____ State _____ Zip _____

Contact for: Cancer Control Data Management Pharmacy Designee
(Check all that apply) Cancer Treatment Regulatory Research Nurse

Additional Staff

Name (First, Middle, Last) _____ Credentials _____

Title at Site _____ Role at Site _____

Phone Number () _____ Fax () _____

E-mail Address _____

Mailing Address _____

City _____ State _____ Zip _____

Contact for: Cancer Control Data Management Pharmacy Designee
(Check all that apply) Cancer Treatment Regulatory Research Nurse

Membership Application

Additional Contact Information

Participating Physician

NCI Number _____

Name (First, Middle, Last) _____ Credentials _____

Title at Site _____ Specialty _____

Phone Number () _____ Fax () _____

E-mail Address _____

Mailing Address _____

City _____ State _____ Zip _____

Participating Physician

NCI Number _____

Name (First, Middle, Last) _____ Credentials _____

Title at Site _____ Specialty _____

Phone Number () _____ Fax () _____

E-mail Address _____

Mailing Address _____

City _____ State _____ Zip _____

Additional Staff

Name (First, Middle, Last) _____ Credentials _____

Title at Site _____ Role at Site _____

Phone Number () _____ Fax () _____

E-mail Address _____

Mailing Address _____

City _____ State _____ Zip _____

- Contact for: Cancer Control Data Management Pharmacy Designee
(Check all that apply) Cancer Treatment Regulatory Research Nurse

Additional Staff

Name (First, Middle, Last) _____ Credentials _____

Title at Site _____ Role at Site _____

Phone Number () _____ Fax () _____

E-mail Address _____

Mailing Address _____

City _____ State _____ Zip _____

- Contact for: Cancer Control Data Management Pharmacy Designee
(Check all that apply) Cancer Treatment Regulatory Research Nurse

Membership Application

Clinical Research Participation

NCI-Sponsored Affiliations

	Yes	No
Eastern Cooperative Oncology Group (ECOG)	<input type="checkbox"/>	<input type="checkbox"/>
Southwest Oncology Group (SWOG)	<input type="checkbox"/>	<input type="checkbox"/>
Cancer and Leukemia Group B (CALGB)	<input type="checkbox"/>	<input type="checkbox"/>
North Central Cancer Treatment Group (NCCTG)	<input type="checkbox"/>	<input type="checkbox"/>
National Surgical Adjuvant Breast & Bowel Project (NSABP)	<input type="checkbox"/>	<input type="checkbox"/>
Radiation Therapy Oncology Group (RTOG)	<input type="checkbox"/>	<input type="checkbox"/>
Gynecologic Oncology Group (GOG)	<input type="checkbox"/>	<input type="checkbox"/>
Children's Oncology Group (COG)	<input type="checkbox"/>	<input type="checkbox"/>
American College of Surgeons Oncology Group (ACOSOG)	<input type="checkbox"/>	<input type="checkbox"/>
H. Lee Moffitt Cancer Center (HLMCC)	<input type="checkbox"/>	<input type="checkbox"/>
University of Rochester Cancer Center (URCC)	<input type="checkbox"/>	<input type="checkbox"/>
Wake Forest University Cancer Center (WFUCC)	<input type="checkbox"/>	<input type="checkbox"/>
University of Michigan Cancer Center (UMCC)	<input type="checkbox"/>	<input type="checkbox"/>
Fox Chase Cancer Center (FCCC)	<input type="checkbox"/>	<input type="checkbox"/>
Clinical Trials Support Unit (CTSU)	<input type="checkbox"/>	<input type="checkbox"/>
Percent of Enrollment that is from NCI-sponsored affiliations	%	

Non-NCI Affiliations

(Ex. Hoosier Oncology Group, Sarah Cannon Research...)

Percent of enrollment that is from non-NCI affiliations %

Industry-Sponsored Affiliations

Percent of enrollment that is from industry-sponsored studies %

Site-Specific/Investigator Initiated Affiliations

Percent of enrollment that is from site-specific/investigator initiated studies %

Membership Application

Number of Newly Diagnosed Cancer Patients

This section may be completed using total CCOP site numbers or by components, whichever is more appropriate. Please provide figures for the table below. Use new cases diagnosed or receiving treatment at that center, except for basal cell or squamous cell carcinoma of the skin. If necessary, submit separate sheets for each component.

Component Name _____

Site NCI Number _____

Information Source: Hospital Registry Regional Registry Other:
 Population Based Registry Hospital Discharge Data _____

	Calendar Year			Calendar Year	
	2006	2007		2006	2007
Breast Tumor			Non-Small Cell Lung		
Esophagus			Hodgkin's Disease		
Stomach			Non-Hodgkin's Lymphoma		
Pancreas			Kaposi's Sarcoma		
Hepatobiliary			Melanoma		
Colon			Head/Neck Tumors		
Rectum			Brain/Other CNS Tumors		
GI (Other)			Endocrine		
Bladder			Osteogenic Sarcoma		
Kidney			Soft Tissue Sarcoma		
Prostate			Rhabdomyosarcoma		
Testis			Ewing's Sarcoma		
GU (Other)			Sarcoma (Other)		
Cervix			Wilm's Tumor		
Ovary			Neuroblastoma		
Uterus, Endometrial			Pediatric ALL		
GYN (Other)			Pediatric AML		
Myeloma			Pediatric Acute Leukemia (Other)		
Adult Acute Lymphocytic Leukemia			Pediatric Lymphomas		
Adult Acute Non-Lymphocytic Leukemia			Pediatric Solid Tumors		
Chronic Leukemia			Other		
Small Cell Lung			Total:		

Membership Application

Additional Information

Total number of new cancer cases per year _____

Percentage of new patients enrolled on clinical trials per year _____

Average number of clinical trials open per year _____

Number/percentage of clinical trials: treatment protocols _____

Number/percentage of clinical trials: cancer control/supportive care protocols _____

Are standard operating procedures in place for drug management? _____

Is your site capable of meeting the minimum accrual requirements of 5 enrollments per year?

How are protocols implemented at your site? By PI? By committee?

How are patients screened for a protocol? By physicians? By patient schedule? By disease-specific committees? By tumor boards?
