|  |  |
| --- | --- |
| Study code/acronym |  |
| Planned start date |  |
| End date |  |
| Principal investigator |  |
| Company |  |
| Contact person company/CRO  Name, tel., e-mail |  |

For every department involved in a trial (with the exception of pharmacy, radiology, laboratory and pathology), the questionnaire below needs to be completed and sent to the clinical trial coordinator, or to the person responsible for the department.

|  |  |
| --- | --- |
| Department: | |
| Will additional investigations or consultations be needed for this trial? Please add a detailed protocol and time schedule of the events. |  |
| Are there specific forms to be completed? | Yes, please add the forms to this request form  No |
| Does the study protocol imply investigations that are requested specifically for the purpose of the study and consequently can not be charged to the patient/RIZIV? | Yes  No |
| Expected number of patients to be included? |  |
| Remarks: | |