



Investigator Registration Form

Please complete and fax this form to 604-676-5911

PART 1: CONTACT INFORMATION

1. NAME: _____
2. TITLE (circle): Dr. Mr. Mrs. Ms.
3. ADDRESS: _____

4. PHONE: () _____
5. FAX: () _____
6. EMAIL: _____

PART 2: TRAINING AND EXPERIENCE

7. EDUCATION:

Year	Institution	Degree/Designation
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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9. SUMMARY OF EXPERIENCE AND RESEARCH INTERESTS:

Registrants may attach a CV. Please note any previous experience in the conduct of clinical research studies.

PART 3: ETHICAL REVIEW COMMITTEE INFORMATION

10. Are you affiliated with an institution or location which has its own Institutional Review Board or Ethics Committee (circle):

Yes No

10a. If yes, please provide name and address of the Ethical Review Committee:

PART 4: SIGNATURE

Signature

Date (dd-mmm-yy)

*Thank you for your interest in joining Syreon's Clinical Investigator Registry.
We will contact you in the event of a study requiring Investigators with your qualifications.*