

## ACRIN Statement of Investigator

Please indicate your acceptance of the investigator responsibilities by checking "Yes" in box # 4, typing your name in box # 5, and dating this statement in box # 6.

ACRIN Protocol # \_\_\_\_\_

**1. Principal Investigator's Name and Address (E-mail the investigator's CV along with this form.)**

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**2. Name(s) of Sub-investigator(s) (List persons who will be assisting the investigator in the conduct of the research such as associates, research fellows, or residents.)**

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**3. All Facility Name(s) and Address(es) Where the Research will be Conducted (The facilities could include a medical school, hospital or related clinic freestanding imaging center, or other research facility.)**

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**4. Principal Investigator Responsibilities**

I agree to conduct the study(ies) in accordance with the relevant, current protocol(s) and will only make changes in a protocol after notifying ACRIN except when necessary to protect the safety, rights, or welfare of subjects.

I agree to personally conduct or supervise the described investigation(s).

I agree to report to ACRIN adverse experiences that occur in the course of the investigation(s) as specified in the ACRIN Adverse Event Manual.

I agree to ensure that all associates, colleagues, and employees assisting in the conduct of the study(ies) are informed about their obligations in meeting the above commitments.

I agree to maintain adequate and accurate records as dictated by good clinical practice. These will be available for inspection in accordance with the ACRIN audit guidelines.

I will ensure that an IRB will be responsible for the initial and continuing review and approval of the clinical investigation. I also agree to promptly report to the IRB all changes in the research activity and all unanticipated problems involving risks to human subjects or others. Additionally, I will not make any changes in the research without IRB approval, except where necessary to eliminate apparent immediate hazards to human subjects.

I agree to comply with all other requirements regarding the obligations of clinical investigators.

I agree  Yes  No to follow and be bound by the responsibilities as outlined above.

5. Investigator Name \_\_\_\_\_

6. Date \_\_\_\_ - \_\_\_\_ - \_\_\_\_