



PVDOMICS STUDY

Study Personnel Form #10

Instructions: Complete and enter a separate form for each person who will be collecting data used in the PVDOMICS Study. These center-related forms can be updated at any time and as often as needed.

Use this form to inactivate former PVDOMICS staff members as well. (To do this, go to Q4a-Staff Member Status. Place the cursor on the row of the individual you want to inactivate, type in "2=inactive". Update the date the staff member became inactive in Q4b.)

1. Clinical Center Number* ____ ____
 11=Brigham and Women's Hospital, Boston, MA
 21=Columbia University, New York, NY
 22=Cornell University, New York, NY
 31=Johns Hopkins University, Baltimore, MD
 41=Mayo Clinic, Rochester, MN
 51=University of Arizona, Tucson, AZ
 61=Vanderbilt University, Nashville, TN

2. a. Last name* _____
 b. First name* _____
 c. PVDOMICS Study Username*
 (The username will be populated automatically unless generated Username is not unique.)
 d. E-mail Address* _____
 e. Cell phone (____ ____) ____ ____ - ____ ____
 f. Phone Number* (____ ____) ____ ____ - ____ ____
 g. Extension _____

3. Primary role in the PVDOMICS study*? ____ ____

01=Site PI 02=Other Physician 03=Physician's Assistant 04=Nurse Practitioner 05=Senior Study Coordinator 06=Study Coordinator 07=Study Nurse, not serving as study coordinator 08=Data Entry 09=Lab Technician (Processing and Shipping) 10=Other Participating Site team member	20=Cardiac Sonographer 21=Cardiac MRI Technologist 22=PFT technician 23=Other investigator (MD or PhD) working with MRI data 24=Polysomnologist 25=ECG Tech 32=CT Radiology Technician
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4. a. Staff member status* (1=active, 2=inactive) ____
Everyone is active when the study starts.
If someone leaves, their status needs to be changed to inactive.
 b. If 4a=2, date staff member became inactive (mm/dd/yyyy) ____ ____ / ____ ____ / ____ ____

*=Required Fields

Individual Certifications Needed

Each center will be responsible for submitting all certifications/qualifications required for each Core.

Sonography Qualification

5. Date qualified in ECHO (Sonographer) (mm/dd/yyyy) ____/____/____

Biorepository Core Certification

6. Date written exam approved by Biorepository Core (mm/dd/yyyy)..... ____/____/____

Lung CT MOP and Appendices Attestation (Technologists and Coordinators)

7. Date technologist reviewed the Manual of Operations and Appendices
and signed attestation statement (mm/dd/yyyy)..... ____/____/____

200. Date form completed (mm/dd/yyyy)..... ____/____/____

201. Username of person completing/reviewing completeness of this form..... _____

Clinical Center Use Only

Date Form Entered (mm/dd/yyyy) ____/____/____

Username of person entering this form _____