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| **Title:** | |  | | | | | | |
| **Given Name/s:** | |  | | | | | | |
| **Surname:** | |  | | | | | | |
| **Profession:** | |  | | | | | | |
| **Affiliation Name:** | |  | | | | | | |
| **Street Address:** | |  | | | | | | |
| **City:** |  | | **State:** | | Choose an item. | | **Postcode:** |  |
| **Phone:** | |  | | Mobile: | |  | | |
| **Email:** | |  | | | | | | |
| **Study Location Name: if different** | |  | | | | | | |
| **Street Address:** | |  | | | | | | |
| **City:** |  | | **State:** | | Choose an item. | | **Postcode:** |  |
| **Phone:** | |  | | **Extension:** | |  | | |
| **Email: If different** | |  | | | | | | |

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| **EDUCATION** | | |
| **University** | **Degree** | **Year completed** |
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| **MEDICAL EDUCATION** | | |
| **University** | **Degree** | **Year completed** |
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| **PROFESSIONAL EXPERIENCE/OTHER RELATED TRAINING** | | |
| **Institution** | **Medical Field** | **Year (Completed)** |
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| **Professional License Number:** | |  | | | | | | | | | |
| **State/Region/Province:** | |  | | | | | | | | | |
| **Expiration Date:** | |  | | | | | | | | | |
| **Research Area(s) of Interest:** | |  | | | | | | | | | |
| **Clinical Trial Phases:** | **Pilot** | | **I** | | **II** | **III** | | **IV** | |
| **List your most Current Clinical Research below:** | | | | | | | | | | | |
| **Therapeutic Area:** | | | | **Type of Trial** | | | **Phase:** | | **Completed** | | **Ongoing** |
|  | | | | Choose an Item | | |  | |  | |  |
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| **GCP Training Course Provider:** |  | **Date Completed:** |  |

**By signing this form, I confirm that the information provided on this Abbreviated CV is accurate and reflects my current employment and qualifications:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Signature:** |  | **Date:** |  |