CLiNSOL CONSULTANCY SERVICES

NEW SITE REGISTRATION FORM

Institution Name:			
Address:			
	City:	State:	
	Country:	Pin Code:	
Institution Type	☐ Government Hospital	☐ Private Hospital	No. of Beds: ________
Type of Hospital	☐ Multispecialty	☐ Non-Multispecialty	☐ NABH Hospital

Section 1.0	**Primary Contact Details**	
Name		Designation:
Contact Number		E-mail ID:

Section 2.0 — **List of Interested Doctors/Investigators**

Sr.	**Therapeutic Area**	**Available in Hospital**	***Name of Doctor/Investigator**
01	Oncology	☐ Y ☐ N	
02	Dermatology	☐ Y ☐ N	
03	Neurosciences (Psychiatry)	☐ Y ☐ N	
04	Respiratory	☐ Y ☐ N	
05	Orthopedic	☐ Y ☐ N	
06	Gastroenterology	☐ Y ☐ N	
07	Ophthalmology	☐ Y ☐ N	
08	Gynecology	☐ Y ☐ N	
09	General Medicine	☐ Y ☐ N	
10	Others: ________________	☐ Y ☐ N	
11	Others: ________________	☐ Y ☐ N	
12	Others: ________________	☐ Y ☐ N	

Y=Yes **N**= No **To capture the detailed information of Doctors/Investigators, Refer Section: 6.0*

Section 3.0 — **Site Infrastructure Details**

Instrument	**Available**	**Calibrated**	**Instrument**	**Available**	**Calibrated**
Deep Freezer-20°C	☐ Y ☐ N	☐ Y ☐ N	Deep Freezer-70°C	☐ Y ☐ N	☐ Y ☐ N
Normal Centrifuge	☐ Y ☐ N	☐ Y ☐ N	Cooling Centrifuge	☐ Y ☐ N	☐ Y ☐ N
Refrigerator	☐ Y ☐ N	☐ Y ☐ N	ECG	☐ Y ☐ N	☐ Y ☐ N
Weighing Scale	☐ Y ☐ N	☐ Y ☐ N	Stature Meter	☐ Y ☐ N	☐ Y ☐ N
Respiratory monitor	☐ Y ☐ N	☐ Y ☐ N	Weighing Balance	☐ Y ☐ N	☐ Y ☐ N
BP apparatus	☐ Y ☐ N	☐ Y ☐ N	2D ECHO	☐ Y ☐ N	☐ Y ☐ N
CT scan	☐ Y ☐ N	☐ Y ☐ N	X-ray	☐ Y ☐ N	☐ Y ☐ N

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Height Meter	☐ Y ☐ N	☐ Y ☐ N	Pulse Oximeter	☐ Y ☐ N	☐ Y ☐ N
MRI	☐ Y ☐ N	☐ Y ☐ N	Endoscopy	☐ Y ☐ N	☐ Y ☐ N
Ultrasound	☐ Y ☐ N	☐ Y ☐ N	Hygrometer	☐ Y ☐ N	☐ Y ☐ N

Available Facility at Site			
Photocopier	☐ Y ☐ N	Printer	☐ Y ☐ N
Computer/Laptop	☐ Y ☐ N	Internet	☐ Y ☐ N
Cupboard	☐ Y ☐ N	STD/ISD Facility	☐ Y ☐ N
Fireproof Drug Storage Area	☐ Y ☐ N	Fax Facility	☐ Y ☐ N
Separate space for Documentation	☐ Y ☐ N	Fireproof Storage/ Archival Area	☐ Y ☐ N
Facility for Audio Visual Recording	☐ Y ☐ N	Separate Room for Monitoring	☐ Y ☐ N
Power Backup	☐ Y ☐ N	Site Specific SOP /Process	☐ Y ☐ N
Storage Facility	☐ Y ☐ N	Fire Alarm	☐ Y ☐ N
Others: __________	☐ Y ☐ N	Others: __________	☐ Y ☐ N

Available Investigation Facility at Site				
Facility	**Status**	**MOU Available (If External)**	**Accredited**	**Accreditation (NABL, CAP, ISO)**
Pathology Laboratory	☐ Internal ☐ External	☐ Y ☐ N	☐ Y ☐ N ☐ NA	
Radiological Investigations	☐ Internal ☐ External	☐ Y ☐ N	☐ Y ☐ N ☐ NA	
Intensive Care Unit (ICU)	☐ Internal ☐ External	☐ Y ☐ N	☐ Y ☐ N ☐ NA	
Emergency Unit	☐ Internal ☐ External	☐ Y ☐ N	☐ Y ☐ N ☐ NA	

Staff Details (If Applicable)			
Total No. of CRC		Full time	☐ Y ☐ N
Total No. of Study Nurse			
Total No. of Study Pharmacist			
Total No. of Phlebotomist			
Total No. of Psychologist			
GCP Trained	☐ Y ☐ N	Experience column	☐ Y ☐ N, If Yes: ________Yrs.

Section 4.0	**Department Details**	
Site Audited by any Regulatory Authority / by Sponsor	☐ Y ☐ N	Name of Regulatory:
Engagement with any professional SMO	☐ Y ☐ N	
Bio-Waste Destruction Facility Available	☐ Y ☐ N	

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Patient database maintenance at site	☐ Y ☐ N
Medical Record Department	☐ Y ☐ N
Satellite Site (Facility)_______________	☐ Y ☐ N

Section 5.0	Ethics Committee (EC) Details		
Ethics Committee Institutional	☐ Y ☐ N	Ethics Committee Independent	☐ Y ☐ N
Ethics Committee SOP Available	☐ Y ☐ N	Ethics Committee Registered with CDSCO	☐ Y ☐ N
EC Registration Number			
Registration Due Date		Scientific Committee at your Site	☐ Y ☐ N
EC Fees Amount in INR	₹ _______________ ☐ Including GST ☐ Excluding TDS		
EC Fees Cheque to be made in Favor of			
Hospital Overhead Charges (If Any)	₹ _______________ ☐ Including GST ☐ Excluding TDS		

Section 6.0	*Interested Doctors/Investigators Details

Name (1):	**Qualification:**
Therapeutic Area:	Designation / Affiliation with Institute:
Contact Number:	E-Mail ID:
MRC Reg No:	
Experience in Clinical Trial: ☐ Y ☐ N	Experience in PK Trial: ☐ Y ☐ N
Preferable Time to Contact:	Associated with any Company /Advisory Committee: ☐ Y ☐ N

Previous Trials Experience Details

Sr. No.	Disease	Drug Name/Device Name	Phase	Role	Completed/ Ongoing	Regulatory Status
1				☐ PI ☐ Co-I		
2				☐ PI ☐ Co-I		
3				☐ PI ☐ Co-I		
4				☐ PI ☐ Co-I		
5				☐ PI ☐ Co-I		

Form Completed By:	**Signature with Date:** _______________