

PHYSICIAN INFORMATION FORM

Date form completed:  <sup>M</sup> <sup>M</sup> /  <sup>D</sup> <sup>D</sup> /  <sup>Y</sup> <sup>Y</sup>

Name of person completing form: \_\_\_\_\_ Phone #: ( \_\_\_\_\_ ) \_\_\_\_\_

**Physician Information**

Physician Last Name:

Physician First Name:

Title (please check):  MD  PhD  Other, specify \_\_\_\_\_

Institution Name Line 1:

Institution Name Line 2:

Mailing Address Line 1:

Mailing Address Line 2:

City:

State:  Zip Code:  -

Phone:  -  -  Ext.

Fax:  -  -

E-mail Address:

**Contact Person Information**

For data management purposes, the LGL Leukemia Registry may need to contact you in the future. Please provide us with information on a contact person (e.g. secretary, nurse) that will be able to assist us. If the physician is the only contact at your institution, please leave this section blank.

Contact Last Name:

Contact First Name:

Position (e.g. secretary):

Title (please check):  RN  LPN  PharmD  MD  PhD  Other, specify \_\_\_\_\_

Phone:  -  -  Ext.

Fax:  -  -

E-mail Address:

Is this person our (please check):  Primary contact (contact this person prior to or instead of contacting physician directly)  
**OR**  
 Secondary contact (contact this person only if physician cannot be reached)

**Introduction to LGL Leukemia Registry**

How were you first introduced to the LGL Leukemia Registry (or The Registry Director, Thomas P. Loughran, Jr., M.D.)? (please check)

- Advertisement for LGL Leukemia Registry, please specify publication: \_\_\_\_\_
- Literature written by LGL Leukemia Registry Director, please specify: \_\_\_\_\_
- Referral from other medical research related to LGL Leukemia, please specify: \_\_\_\_\_
- Previous working relationship with LGL Leukemia Registry Director
- Other, please specify: \_\_\_\_\_