Large Granular Lymphocyte (LGL) Leukemia Registry
PHYSICIAN INFORMATION FORM

Date form completed: M M / D D / Y Y

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: _____

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Physician Information

Physician Last Name:

Physician First Name:

Title (please check): ☐ MD ☐ PhD ☐ Other, specify _____

Institution Name Line 1:

Mailing Address Line 1:

City:

State: Zip Code: -

Phone: - - Ext.

Fax: - -

E-mail Address:

Contact Name (Last, First)

Title (please check): ☐ RN ☐ LPN ☐ PharmD ☐ MD ☐ PhD ☐ Other, specify _____

Phone: - - Ext.

Fax: - -

E-mail Address:

Is this person our (please check): ☐ Primary contact **OR** ☐ Secondary contact

Physician Information

Physician Last Name:

Physician First Name:

Title (please check): ☐ MD ☐ PhD ☐ Other, specify _____

Institution Name Line 1:

Mailing Address Line 1:

City:

State: Zip Code: -

Phone: - - Ext.

Fax: - -

E-mail Address:

Contact Name (Last, First)

Title (please check): ☐ RN ☐ LPN ☐ PharmD ☐ MD ☐ PhD ☐ Other, specify _____

Phone: - - Ext.

Fax: - -

E-mail Address:

Is this person our (please check): ☐ Primary contact **OR** ☐ Secondary contact