

Unmasking Record

Patient ID: _____
Patient Initials: _____
Clinical Center: _____
Contact Week: _____
Date: ____ / ____ / ____

month day year

RC ID: _____

(Research Coordinator completed) (Photocopies of this form with signature must be sent to the DCC.)

1. Date of unmasking: _____ Date: ____ / ____ / ____
month day year
2. Time of unmasking: ____ : ____ (Military time)
3. Was the DCC contacted within 3 days of unmasking? ☐₁ Yes ☐₀ No
If **YES**, name of person contacted: _____
If **NO**, give reason: _____
4. Who unmasked the drug? ☐₁ P.I.
☐₂ RC
☐₃ Other
5. If unmasked by someone other than the P.I., was the P.I. contacted prior to unmasking?
☐₁ Yes ☐₀ No
If **NO**, give reason: _____
6. Why was the drug unmasked? ☐₁ Serious Adverse Event as recorded on AE/SAE form as AE # ____
☐₂ Other hospitalization
☐₃ Other, please specify: _____

Signature: _____
Principal Investigator

Date: _____

Did the P.I. sign this form? ☐ ₁ Yes ☐ ₀ No

Place unmasked white drug label here:

Place unmasked green drug label here: