

I C C T G	ICCTG	Study Close-out	Patient ID: _____
	PROTOCOL #1		Patient Initials: _____
			Clinical Center: _____
			Contact Week: _____
			Date: ____ / ____ / ____ month day year
			RC ID: _____

(Physician and Research Coordinator completed when patient stops participating in the study.)

1. Physician Comments (Optional):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**SIGNATURES: Please complete the following section regardless of the reason for termination of study participation.**

I verify that all information collected on the ICCTG data collection forms for this subject is correct to the best of my knowledge and was collected in accordance with the procedures outlined in the ICCTG Protocol and Manual of Procedures.

_____	Date: ____ / ____ / ____ month day year
Principal Investigator Signature	
Did the P.I. sign this form? <input type="checkbox"/> _1 Yes <input type="checkbox"/> _0 No	
_____	Date: ____ / ____ / ____ month day year
Research Coordinator Signature	
Did the R.C. sign this form? <input type="checkbox"/> _1 Yes <input type="checkbox"/> _0 No	