I C C T G ICCTG PROTOCOL #1	Study Close-out	Patient ID: ___ ___ ___ ___ ___ 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? ❒1 Yes ❒0 No

_____ Date: __ __ / __ __ / __ __
month day year
Research Coordinator Signature
Did the R.C. sign this form? ❒1 Yes ❒0 No