

CTMS New Site Intake Form

Participating Organization: Vancouver Coastal Health

Research Group Name:

Main Point of Contact:

Site Street Address:

City, Province, Postal
Code:

Phone:

Fax:

Main Contact Email:

Desired Site ID*:

*Please use abbreviations only (E.g. Clinical Research Unit = CRU)

As Authorizer, I attest that my organization has agreed to provision CTMS access to this site,
and that the site is eligible to participate.

Authorizer signature:

Name

Signature

Date