

IMP TRANSFER FORM

Trial Code:		Sponsor:	
SENDING SITE - Site No.:			
Principal Investigator Name:			
Site address:			
Reason for transfer:			
INVESTIGATIONAL MEDICINAL PRODUCT (IMP)			
IMP Name, Formulation and strength	Batch No.	Amount	Expiry date mm/yyyy
Shipment conditions:			
Comments:			
Person responsible for the <u>IMP shipment</u> - Name: Role: Phone No.: email: Signature: _____ Date: _____			
NOTE: Please, <u>enclose original signed document in the shipment package</u> and file a copy in the Investigator Site File (to be replaced by the copy countersigned by the receiving site).			

RECEIVING SITE - Site No.:		
Principal Investigator Name:		
Site address:		
Person responsible for the <u>IMP receipt</u> - Name: Role: Phone No.: email:		
IMP received in proper conditions (e.g., temperature, packaging)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No (If no add comment below)
Comments:		
Signature: _____ Date: _____		
<i>NOTE: Please, send copy of countersigned and dated form to PM/DM and to the Sending Site (see above for contact details) and file the original form in the Investigator Site File of the receiving site.</i>		