CLINICAL RESEARCHER'S DIRECTORY FORM

Name				
Designation				
Telephone				
Email				
Number of years of medical experience				
List of Qualifications				
Number of studies performed	☐ 1-5	☐ 5-10	☐ 10-20	☐ >20
Are you aware of International Research Guidelines		☐ Yes	☐No	
If yes, (Check all that apply)	☐ ICH-GCP	☐ US-FDA	☐ Jordanian FDA	☐Saudi FDA

Names of hospitals that you are affiliated with

1.
2.
3.

Therapeutic Area of interest (Tick all that apply)

Cardiology	☐	Hepatology	☐	Attach Your Photo Here
Critical care medicine	☐	Infectious diseases	☐	
Emergency medicine	☐	Nephrology	☐	
Endocrinology	☐	Oncology	☐	
Gastroenterology	☐	Pediatrics	☐	
Geriatrics	☐	Pulmonology/Pneumology	☐	
Haematology	☐	Rheumatology	☐	
Sleep medicine	☐	Psychology	☐	

Others (Please Specify): _____

Please Write your biography (100 Words) Please Note that this will appear in our directory

Agreement

I confirm that all the filed information is correct. By disclosing this information to ClinArt, I agree that ClinArt can share the information with other interested parties as per ClinArt judgment. After signing this form, the included information becomes a property of ClinArt.

Signature:		Date:	/ /

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