1. Section to be completed and signed, then emailed to OSROStudyAgent.

Date Form Completed: _____

Responsible Parties:

	Transferer	Receiver	Additional Information (if applicable)*
Investigator of Record (IOR) Name:			
IOR Telephone:			
IOR Email:			
Protocol Number:			

*Contact information in case of site-to-site and/or NIH to non-NIH transfers.

Investigational Product(s):

	Item 1	Item 2	Item 3	Item 4
Drug Name:				
IDMS Lot #:				
Manufacturer:				
Manufacturer Lot #:				
Expiration Date:				
Quantity To Transfer:				
Current Location:				

Reason for Transfer:

☐ Protocol closure ☐ IP expiration ☐ Other (specify):

Section 1 completed by:

_____

Transferring IOR Approval:

_____

Receiving IOR Approval:

_____

2. Section to be completed by OSRO Pharmaceutical Management and/or designee.

- ☐ Drug accountability log and reported current inventory match
- ☐ IP storage temperature logs have been reviewed for temperature excursions, if applicable
- ☐ Manufacturer and/or supplier has given authorization for the transfer, if applicable

Section 2 completed by:

_____

Transfer request approved by:

_____

Note: Copies of the signed form are to be provided to the transferring IOR, the receiving IOR and the current site storage location.