



Site Intake Form

Date Completed: _____

Please return your completed form to customercare@dcndx.com

Site Name		
Main Contact (name/role): Email Address:		
Phone:		
24/7 Phone:		
Site Physical Address	Site Name: Address: City, State, Zip:	
Site Shipping Address (Please enter address where you will receive study supplies)		
Principal Investigator	Email Address	Phone Number
Sub-Investigator(s)	Email Address	Phone Number
Site Coordinator(s)	Email Address	Phone Number
Contract Contact	Email Address	Phone Number
Budget Contact	Email Address	Phone Number
Regulatory Contact	Email Address	Phone Number

Site Intake Form

Criteria	Comments	Check
Investigator/Site Experience		
Does the Principal Investigator have previous experience with: 1. Clinical Research? 2. Study Population?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
Describe the type of site you are	Emergency Care Outpatient Clinic Pediatric Clinic Hospital Physicians' office Laboratory Other?	
Does your site have any ongoing competing studies?	If yes, please specify: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
What is your current positive prevalence at your site for the following: 1. COVID-19 2. Flu A 3. Flu B 4. RSV	# per week _____ # per week _____ # per week _____ # per week _____	
How many studies/trials is your site currently recruiting	Total "Open and enrolling": Total in "Follow-up phase":	
Do you enroll geriatric and/or pediatric population? Percentage of population?		
What is the area of research interest for the Principal Investigator? 1. Respiratory 2. Sexual Health 3. Women's Health 4. Infectious Diseases (HCV, HIV, HBV) 5. Other, please specify		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
How many patients do you estimate your site can enroll for the study?	___ per week ___ per day	
Number of clinical trial coordinators do you have employed at your site?		
Number of Sub-Investigators? (if applicable)	Name: Name: Name:	

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What is the number of clinical trials your site has conducted in the last five (5) years?	Please specify, if yes: _____	
Does your site have a CLIA/CAP Certificate?	CLIA Certificate CAP Certificate	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
Does your site have a Federal wide Assurance (FWA) Certificate?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Has your site been inspected by the FDA, or have you ever received a warning letter from FDA?	Please ensure that you attach a copy of 483, if applicable.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Facilities and Equipment		
What types of freezers does your site have access to? 1. -20°C 2. ≤ -80 °C	# of freezers on-site: _____ # of freezers off-site: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
Does your site have adequate, secure storage space for investigative use only product?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your site have access to a 2-8°C refrigerator?	# of refrigerators on-site: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your site have access to dry ice?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Regulatory/Budget/Contracting		
What is your site/institutions overhead?	___% for one visit patient visits	
For contract/budget negotiations, what is the typically turnaround period?		
What is your site/institutions preferred IRB? 1. Local IRB 2. Central IRB		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
If your site/institution uses a local IRB, how long is the approval process?		

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