DATA CLARIFICATION FORM (DCF)

<Name of STUDY / PROJECT>

Protocol No:	**Country:**	**Site:**
PI name:	Originator:	**Date written:**
DCF No:	**Patient Number:**	**Patient initials:**

CRF page	Question	Response

1. Respond to the question in the response box to the right
2. Sign and date this form
3. Attach a copy to the patients' CRF on site
4. Return the original DCF back to Data Management within …. working days

Return address: *<email> or <Fax> or <DM address>*		
Changes authorized by	Signature	Date