**1. CLINICAL TRIAL NAME**

[Insert the name of the clinical trial associated with the records to be destroyed]

1. **PRINCIPAL INVESTIGATOR**

[Insert the name of the Principal Investigator associated with the clinical trial specified above]

1. **HUM/IRB APPROVAL NUMBER**

[Insert the HUM/IRB approval number associated with the clinical trial]

1. **NCT NUMBER N/A**

[Insert the NCT number associated with the clinical trial or select N/A if not applicable]

1. **AUTHORIZATION TO DESTROY CLINICAL TRIAL STUDY DOCUMENTATION**

This document authorizes the destruction of the following documents:

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| --- | --- | --- |
| **Document Type/Name** | **Date Destroyed** | **Destroyed by (Name)** |
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1. **INDUSTRY SPONSOR CONTACT INFORMATION □ N/A**

[Insert the contact information for the Industry Sponsor of the clinical trial, (or select N/A if approval from an Industry Sponsor is not required) prior to destroying clinical trial study documentation]

For sponsor authorization to destroy the documents specified above, please contact:

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| --- | --- |
| **Name** |  |
| **Title** |  |
| **Organization** |  |
| **Address** |  |
| **Telephone Number** |  | **Email Address** |  |
| **Comments** |  |

1. **LEAD ARCHIVIST/DESIGNEE CONTACT INFORMATION**

For information regarding the record destruction process and related documentation, please contact:

|  |  |
| --- | --- |
| **Name** |  |
| **Title** |  |
| **Organization** |  |
| **Address** |  |
| **Telephone Number** |  | **Email Address** |  |
| **Comments** |  |

1. **APPROVAL**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
| Sponsor Contact Name (please print) |  | Signature  |  | Date |

|  |  |  |  |  |
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|  |  |  |  |  |
| Principal Investigator/Designee (please print) |  | Signature  |  | Date |