

**Outpatient Investigational Drug
Storage Information Form
&
Acknowledgement of Responsibility Sheet
(Complete for each Study Drug Supplied by the Study)**

Company Sponsor: _____

Study Drug Location: _____

Person Responsible for Study Drug: _____

Responsible Individual's Phone Number: _____

Responsible Individual's Beeper Number: _____

Acknowledgement of Responsibility

I _____ acknowledge that I will comply with the following requirements for investigational drug storage and the dispensing of investigational agents to outpatients.

1. All patients will have a signed informed consent before entry into the study.
2. All study drugs will be stored under lock and key.
3. My designee or I will accurately maintain dispensing records and monthly audits will be performed.
4. I will allow the Department of Pharmacy or the Office of Research Compliance to audit drug supply and dispensing records upon their request.
5. I understand that Arkansas law requires that a physician must dispense the medication to the patient.
6. I understand that the medication dispensed to the patient will be labeled with the following information.

Patient Name	Date	Name of Study
Patient Study Number		Instructions for Patient
Name of a Study Contact		24 Hours Phone Number

Investigator Signature

Date