

**Penn Pharmaceutical Service
Request Form – Courses 2/3**

Order No: C2950/ _____

CLIENT: **GENZYME** STUDY NO: **AML 17 (CLOFARABINE)**

Please supply the following Medication:

Description of Supplies:	Quantity of packs required:
AML 17 Clofarabine 4 vial kit Item Code: XGEY28	

Site Regulatory Approval in Place:

Yes / No

EudraCT Number: **2007-003798-16**

Center Name.	
Investigator (enter name of Principal Investigator)	
Patient Initials <input type="text"/> <input type="text"/>	Patient Trial Number: 17 - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
	Course: 2 <input type="checkbox"/> 3 <input type="checkbox"/>
Date medication is required (approx. delivery time)	
Delivery contact (CONSIGNEE) (Pharmacist details)	Name: Tel:
Delivery address: (Give full details including department and ward of hospital – or pharmacy location – as appropriate)	
Fax to clinical trials office on 02920 742289	

To be completed by Trials Office staff only

Authorised by (Trials Office personnel): NB: Signature confirms that all regulatory approvals for the investigator site requested are in place and that shipment may proceed.	Signature: _____ Date: _____ Print Name: _____ Tel No: _____ Fax-No.: _____
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PENN PHARMACEUTICALS – DESPATCH DETAILS

Material despatched as requested above:	Y / N *
No of shipment cartons	
Courier: Consignment Note No.:	
Despatched By: (Initials / Date)	
Checked By: (Initials / Date) Supervisor	
Date shipped	

CONSIGNEE – ACKNOWLEDGEMENT OF RECEIPT

Drug supplies received complete and in good condition Y / N * * Circle as appropriate

Package is unopened and undamaged Y / N *

Ensure that drug supplies are stored at 15-25°C and under appropriate conditions

Consignee (Signature / Date) Recipient to sign and date	
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Please fax completed form to

PENN Pharmaceuticals –FAO: Despatch Fax.No: +44 (0) 1495 713743