

## ASSOCIATE MEMBER FORM

An Associate Member of the company is a person who must participate in a Study under the supervision of a Principal Investigator. An Associate Member does not pay a membership fee, as such does not have Membership voting rights, and cannot be a Principal Investigator (PI) of a clinical trial. An associate member is able to attend and participate in relevant ALLG meetings, receive notice of General Meetings, access relevant education and training opportunities. An associate member does not qualify for ALLG Board, Scientific Advisory Committee (SAC), Financial Advisory Committee (FAC) or Safety and Data Monitoring Committee (SDMC) appointment.

Associate Members shall remain a Member for three years, unless sooner determined. At the expiration of this term, unless the membership may be renewed for a further three year term as the Board sees fit, the Associate Member is removed and ceases to be a Member in line with the Constitution, rule 6.

Title (please circle):  Mr  Mrs  
 Ms  Miss  Other: \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Position Title: \_\_\_\_\_

Hospital or Institution: \_\_\_\_\_

Department: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Postcode: \_\_\_\_\_

Country: \_\_\_\_\_

### **Contact Details:**

Phone Number (direct line): \_\_\_\_\_

Pager: \_\_\_\_\_

Email Address: \_\_\_\_\_

Mobile: \_\_\_\_\_

Please tick if you need access to the ALLG website.

Is this a new position?  Yes  No

If **'NO'**, please list the name(s) of the person(s) that previously held your position at your site.  
Providing this information allows the ALLG to maintain an updated database of research nurses and data managers.

Name(s): \_\_\_\_\_  
 \_\_\_\_\_

Please list the current and upcoming ALLG studies you will be managing below.

Current ALLG Studies	Upcoming ALLG Studies
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
6.	6.
7.	7.
8.	8.
9.	9.
10.	10.

**Good Clinical Practice (GCP):**

GCP Training completed (please include date): \_\_\_\_\_

Date of planned GCP Training: \_\_\_\_\_

Please cite the name of an ALLG clinician at your workplace, who can support your request.

**NOTE:** This person must be a current financial member of the Australasian Leukaemia & Lymphoma Group.

Principal Investigator Name: \_\_\_\_\_

Signature: \_\_\_\_\_

**Applicant:**

I \_\_\_\_\_ agree to abide by the Constitution of the Australasian Leukaemia & Lymphoma Group as long as I remain an Associate Member.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_