Complications of Age-related Macular Degeneration (CAPT)

Staff Update Form

Fax to: Claressa Whearry (215) 615-1531

Check one: **( ) Add**
( ) Update (complete center #, staff name, and only information that needs updated)

Date form completed: ___ ___ / ___ ___ / ___ ___ Completed by: _____
Month Day Year

Center: ___ ___ Site: ___Center Name: _____

Name:_____
_
First Middle Last Credentials

E-mail address: _____ Beeper: _____

Check role(s):

( ) Principal Investigator
( ) Participating Ophthalmologist
( ) Clinic Coordinator
( ) Backup Clinic Coordinator
( ) Visual Acuity Examiner
( ) Photographer

Complete the following Address and Phone Number Information only if different from Center information

Address (only if different from Center address):_____
Address City State Zip

Primary phone number (only if different from Center phone number): (_____) _____

Secondary phone number (only if different from Center phone number): (_____) _____

Location of Secondary phone: _____

Fax phone number (only if different from Center phone number): (_____) _____

❑ **REMOVE** the following staff name from the Address Registry.

Name:_____
First Middle Last

Effective Date: ___ ___ - ___ ___ - ___ ___
Month Day Year

Coordinating Center Use Only

Database updated by: _____ Date Completed: __ __ - __ __ - __ __

( ) Copy to Systems Analyst ( ) Original in Registry Notebook

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