IMACS Registry Institutional Enrollment Form

Hospital Name: _____

Affiliated Academic Institution
Name, if any: _____

Hospital Address: _____
City, Country, Postal Code: _____

Program Director Name: _____
Title: _____
Phone (include city/country code): _____
Fax (include city/country code): _____
E-mail Address: _____

Data Coordinator Name: _____
Title: _____
Phone (include city/country code): _____
Fax (include city/country code): _____
E-mail Address: _____

Program Director Signature: _____

Printed Name of Program Director: _____

This form MUST be submitted via e-mail or mail and accompanied by a letter on institutional letterhead signed by the Program Director requesting to participate in the IMACS Registry. Forms submitted without this letter cannot be processed.

Return to: IMACS@uab.edu
University of Alabama at Birmingham
ATTN: IMACS
701 19th St. S., LHRB 790
Birmingham, AL, USA 35294