Study Specific Training Attestation

By signing below, I acknowledge that I have completed the CAPTIVA educational activities on the dates provided.

_____ _____

Printed Name ***Signature***

Study Specific Training required before a site can be "Released to Enroll" or an individual can assume responsibility for delegated tasks:	Principal Investigator Sub-Investigator	Primary Study Coordinator Secondary Study Coordinator	Primary Pharmacist Pharmacy Personnel
Watch Investigator Meeting Videos 1-11	**X**		
Watch Investigator Meeting Videos 1-8		**X**	
Review Protocol v3.0 Summary of Changes PowerPoint Slides	**X**	**X**	
Review Protocol v4.0 Summary of Changes PowerPoint Slides	**X**	**X**	
Watch Stroke In and Out of Territory of the Stenotic Intracranial Artery Training Video	**X**		
Review Pharmacy MOP			**X**

- Watched Investigator Meeting Videos 1-11: Date Completed: _____
- Watched Investigator Meeting Videos 1-8: Date Completed: _____
- Reviewed Protocol v3.0 Summary of Changes Slides: Date Completed: _____
- Reviewed Protocol v4.0 Summary of Changes Slides: Date Completed: _____
- Watched Stroke In & Out of Territory of the Stenotic Intracranial Artery Video: Date Completed: _____
- Reviewed Pharmacy MOP: Date Completed: _____

Upload the completed form in WebDCU™.