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# Application Form for EuroMRD Membership

# Ph+ALL section

#### (For background information: see guidelines for EuroMRD membership d.d. June 2010)

Name :

Department :

Institute :

Address :

E-mail :

Phone :

Fax :

## **I wish to become member of:**

EuroMRD Ph+ALL section

## **Extensive knowledge on RQ-PCR for fusion transcripts**

YES NO

Possibilities and limitations

Sample handling

Control samples

Sensitivity testing

Interpretation of RQ-PCR results (according to EuroMRD guidelines

## **B. Extensive experience in RQ-PCR for MRD detection**

###### Level of experience with RQ-PCR-based MRD diagnostics

RQ-PCR-based MRD diagnostics since (year):

MRD diagnostics according to EuroMRD guidelines: YES: NO:

Trained by/collaboration with:

name of EuroMRD laboratory:

responsible scientist (name):

No. of patients completely analysed (including two follow-up time points):       (at least 25 cases)

No. of patients analysed and approved in full parallel to the above   
mentioned EuroMRD laboratory:       (at least 5 cases)

* Own publications in the field of MRD diagnostics (if available):

## **C. Position of MRD laboratory: size, relation to (inter)national treatment protocols, and annual intake of new patients**

###### Size of MRD laboratory

* No. of scientists:       (at least one)
* No. of technicians:       (at least two)

###### Position of MRD laboratory at national level

Acting as central MRD laboratory for the following MRD-based treatment protocol(s) (please include statement of the chairman of the concerned national treatment protocol):



###### Number of inhabitants which the MRD laboratory covers:

* x 106 inhabitants or whole country

###### Annual intake of new patients with complete MRD diagnostics:

**Protocol Patients Non-Protocol Patients**

Ph+ALL patients

(at least 20 new Protocol Patients per year)

\* A relapsed ALL patient can be regarded as a new patient, if MRD is monitored after relapse

## **Approved by:**

Supervisor / head Chairman of MRD-based Collaborating EuroMRD  
of MRD laboratory treatment protocol laboratory

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name name name

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date date date

**Completed forms should be returned to:**

Dr. C. Eckert

Dept. of Pediatric Oncology and Hematology

Charité CVK

Universitätsmedezin Berlin

Mittelallee 6a, Pav 32, 1.OG

Augustenburger Platz 1

13353 Berlin

Germany

Email address: cornelia.eckert@charite.de