DEPARTMENT OF HEALTH AND HUMAN SERVICES
FOOD AND DRUG ADMINISTRATION

STATEMENT OF INVESTIGATOR

(TITLE 21, CODE OF FEDERAL REGULATIONS (CFR) PART 312)

(See instructions on reverse side.)

Form Approved: OMB No. 0910-0014
Expiration Date: February 28, 2019
See OMB Statement on Reverse.

NOTE: No investigator may participate in an investigation until he/she provides the sponsor with a completed, signed Statement of Investigator, Form FDA 1572 (21 CFR 312.53(c)).

1. NAME AND ADDRESS OF INVESTIGATOR

Name of Principal Investigator
Coyle, Yvonne M.

Address 1	Address 2		
3410 Worth Street, Suites 300 and 400			
City	**State/Province/Region**	**Country**	**ZIP or Postal Code**
Dallas	TX	US	75246

2. EDUCATION, TRAINING, AND EXPERIENCE THAT QUALIFY THE INVESTIGATOR AS AN EXPERT IN THE CLINICAL INVESTIGATION OF THE DRUG FOR THE USE UNDER INVESTIGATION. ONE OF THE FOLLOWING IS PROVIDED *(Select **one** of the following.)*

☒ Curriculum Vitae ☐ Other Statement of Qualifications

3. NAME AND ADDRESS OF ANY MEDICAL SCHOOL, HOSPITAL, OR OTHER RESEARCH FACILITY WHERE THE CLINICAL INVESTIGATION(S) WILL BE CONDUCTED

Name of Medical School, Hospital, or Other Research Facility
Investigational Products Center (IPC), (drug shipment only)

Address 1	Address 2		
13501 Park Vista Blvd., Suite 160			
City	**State/Province/Region**	**Country**	**ZIP or Postal Code**
Fort Worth	TX	US	76177

4. NAME AND ADDRESS OF ANY CLINICAL LABORATORY FACILITIES TO BE USED IN THE STUDY

Name of Clinical Laboratory Facility
Clearpoint Diagnostic Laboratories, LLC

Address 1	Address 2		
2501 S State Hwy 121, Suite 1200			
City	**State/Province/Region**	**Country**	**ZIP or Postal Code**
Lewisville	TX	UNITED STATES	75067

5. NAME AND ADDRESS OF THE INSTITUTIONAL REVIEW BOARD (IRB) THAT IS RESPONSIBLE FOR REVIEW AND APPROVAL OF THE STUDY(IES)

Name of IRB
US Oncology, Inc., IRB

Address 1	Address 2		
10101 Woodloch Forest Drive			
City	**State/Province/Region**	**Country**	**ZIP or Postal Code**
The Woodlands	TX	US	77380

6. NAMES OF SUBINVESTIGATORS *(If not applicable, enter "None")*

See continuation page

7. NAME AND CODE NUMBER, IF ANY, OF THE PROTOCOL(S) IN THE IND FOR THE STUDY(IES) TO BE CONDUCTED BY THE INVESTIGATOR

A Phase 3 Randomized, Double-Blind, Placebo-Controlled Study to Evaluate the Efficacy and Safety of GS-5745 Combined with mFOLFOX6 as First Line Treatment in Patients with Advanced Gastric or Gastroesophageal Junction Adenocarcinoma (GS-US-296-1080)

PSC Publishing Services (301) 443-6740 EF

8. PROVIDE THE FOLLOWING CLINICAL PROTOCOL INFORMATION. *(Select **one** of the following.)*

☐ For Phase 1 investigations, a general outline of the planned investigation including the estimated duration of the study and the maximum number of subjects that will be involved.

☑ For Phase 2 or 3 investigations, an outline of the study protocol including an approximation of the number of subjects to be treated with the drug and the number to be employed as controls, if any; the clinical uses to be investigated; characteristics of subjects by age, sex, and condition; the kind of clinical observations and laboratory tests to be conducted; the estimated duration of the study; and copies or a description of case report forms to be used.

9. COMMITMENTS

I agree to conduct the study(ies) in accordance with the relevant, current protocol(s) and will only make changes in a protocol after notifying the sponsor, except when necessary to protect the safety, rights, or welfare of subjects.

I agree to personally conduct or supervise the described investigation(s).

I agree to inform any patients, or any persons used as controls, that the drugs are being used for investigational purposes and I will ensure that the requirements relating to obtaining informed consent in 21 CFR Part 50 and institutional review board (IRB) review and approval in 21 CFR Part 56 are met.

I agree to report to the sponsor adverse experiences that occur in the course of the investigation(s) in accordance with 21 CFR 312.64. I have read and understand the information in the investigator's brochure, including the potential risks and side effects of the drug.

I agree to ensure that all associates, colleagues, and employees assisting in the conduct of the study(ies) are informed about their obligations in meeting the above commitments.

I agree to maintain adequate and accurate records in accordance with 21 CFR 312.62 and to make those records available for inspection in accordance with 21 CFR 312.68.

I will ensure that an IRB that complies with the requirements of 21 CFR Part 56 will be responsible for the initial and continuing review and approval of the clinical investigation. I also agree to promptly report to the IRB all changes in the research activity and all unanticipated problems involving risks to human subjects or others. Additionally, I will not make any changes in the research without IRB approval, except where necessary to eliminate apparent immediate hazards to human subjects.

I agree to comply with all other requirements regarding the obligations of clinical investigators and all other pertinent requirements in 21 CFR Part 312.

INSTRUCTIONS FOR COMPLETING FORM FDA 1572
STATEMENT OF INVESTIGATOR

1. Complete all sections. Provide a separate page if additional space is needed.
2. Provide curriculum vitae or other statement of qualifications as described in Section 2.
3. Provide protocol outline as described in Section 8.
4. Sign and date below.
5. FORWARD THE COMPLETED FORM AND OTHER DOCUMENTS BEING PROVIDED TO THE SPONSOR. The sponsor will incorporate this information along with other technical data into an Investigational New Drug Application (IND). INVESTIGATORS SHOULD NOT SEND THIS FORM DIRECTLY TO THE FOOD AND DRUG ADMINISTRATION.

10. DATE *(mm/dd/yyyy)*	11. SIGNATURE OF INVESTIGATOR
2016/11/07 09:08:34.389 AM CST	Yvonne Coule I attest to the accuracy and integrity of this document

(**WARNING**: A willfully false statement is a criminal offense. U.S.C. Title 18, Sec. 1001.)

The information below applies only to requirements of the Paperwork Reduction Act of 1995.

The burden time for this collection of information is estimated to average 100 hours per response, including the time to review instructions, search existing data sources, gather and maintain the data needed and complete and review the collection of information. Send comments regarding this burden estimate or any other aspect of this information collection, including suggestions for reducing this burden to the address to the right:

Department of Health and Human Services
Food and Drug Administration
Office of Operations
Paperwork Reduction Act (PRA) Staff
PRAStaff@fda.hhs.gov

"An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB number."

DO NOT SEND YOUR COMPLETED FORM TO THIS PRA STAFF EMAIL ADDRESS.

FIRST CONTINUATION PAGE FOR ITEM 3

NAME AND ADDRESS OF ANY MEDICAL SCHOOL, HOSPITAL, OR OTHER RESEARCH FACILITY WHERE THE CLINICAL INVESTIGATION(S) WILL BE CONDUCTED ***(Enter additional names and addresses below.)***

Name of Medical School, Hospital, or Other Research Facility			
Texas Oncology-Baylor Charles A. Sammons Cancer Center			
Address 1: 3410 Worth Street, Suites 300 and 400		Address 2:	
City: Dallas	State/Province/Region: TX	Country: US	ZIP or Postal Code: 75246

Name of Medical School, Hospital, or Other Research Facility			
N/A			
Address 1:		Address 2:	
City:	State/Province/Region:	Country:	ZIP or Postal Code:

Name of Medical School, Hospital, or Other Research Facility			
N/A			
Address 1:		Address 2:	
City:	State/Province/Region:	Country:	ZIP or Postal Code:

Name of Medical School, Hospital, or Other Research Facility			
N/A			
Address 1:		Address 2:	
City:	State/Province/Region:	Country:	ZIP or Postal Code:

Name of Medical School, Hospital, or Other Research Facility			
N/A			
Address 1:		Address 2:	
City:	State/Province/Region:	Country:	ZIP or Postal Code:

Name of Medical School, Hospital, or Other Research Facility			
N/A			
Address 1:		Address 2:	
City:	State/Province/Region:	Country:	ZIP or Postal Code:

Name of Medical School, Hospital, or Other Research Facility			
N/A			
Address 1:		Address 2:	
City:	State/Province/Region:	Country:	ZIP or Postal Code:

FIRST CONTINUATION PAGE FOR ITEM 4

NAME AND ADDRESS OF ANY CLINICAL LABORATORY FACILITIES TO BE USED IN THE STUDY
(Enter additional names and addresses below.)

Name of Clinical Laboratory Facility Covance			
Address 1 8211 SciCor Drive		Address 2	
City Indianapolis	State/Province/Region IN	Country UNITED STATES	ZIP or Postal Code 46214-2985
Name of Clinical Laboratory Facility Laboratory Corporation of America			
Address 1 7777 Forest Ln Bldg C350		Address 2	
City Dallas	State/Province/Region TX	Country UNITED STATES	ZIP or Postal Code 75230
Name of Clinical Laboratory Facility Med Fusion			
Address 1 2501 S. State Hwy 121, Suite 1100		Address 2	
City Lewisville	State/Province/Region TX	Country UNITED STATES	ZIP or Postal Code 75067
Name of Clinical Laboratory Facility Quest Diagnostic Clinical Laboratories Inc			
Address 1 4770 Regent Blvd.		Address 2	
City Irving	State/Province/Region TX	Country UNITED STATES	ZIP or Postal Code 75063
Name of Clinical Laboratory Facility Texas Oncology Lab - Baylor			
Address 1 3410 Worth Street		Address 2	
City Dallas	State/Province/Region TX	Country UNITED STATES	ZIP or Postal Code 75246-2006
Name of Clinical Laboratory Facility N/A			
Address 1		Address 2	
City	State/Province/Region	Country	ZIP or Postal Code
Name of Clinical Laboratory Facility N/A			
Address 1		Address 2	
City	State/Province/Region	Country	ZIP or Postal Code

CONTINUATION PAGE FOR ITEM 6

NAMES OF SUBINVESTIGATORS ***(Enter additional names below.)***

Denham Jr., Claude A.
Levy, Moshe Y.