
	FORM	FOR-DIIS-042
	CLINICAL TRIAL CANCELLATION REQUEST	Edition No. 01

RNE code:  
(Automatically generated during registration)  
electronic in the REPEC)

I. SPONSOR'S DATA				Foreign:	<input type="checkbox"/>	National:	<input type="checkbox"/>
1. NATURAL PERSON <input type="checkbox"/>							
Father's Surname:		Mother's Surname:					
Names:		DNI/ CE/ PAS:					
Email:		Telephone and extension:					
Legal Address: (District, Province and Department)							
2. LEGAL ENTITY <input type="checkbox"/>							
2.1. FOREIGN SPONSOR (Previously registered in the INS REPEC)							
Registered Name: (According to the Certificate of Incorporation of the company, business or organization or instrument equivalent in the country of origin).		Registered Trade Names: (From the company or organization).					
Commercial registration number:		Names and surnames of the legal representative: (Duly empowered to act as representative of this and grant powers in your name).					
Identity Document Number of the legal representative: (The document equivalent to the country of origin).		Position held in the organization:					
Email:		Telephone and extension:					
Legal address:		Zip code:					
2.1.1. REPRESENTATIVE OF THE FOREIGN SPONSOR IN PERU (Check one of the options)							
<input type="checkbox"/> SUBSIDIARY:	<input type="checkbox"/> BRANCH:	<input type="checkbox"/> OIC:	<input type="checkbox"/> OTHER: _____				
RUC:		Company Name: (Data of your legal representative add them in numerals 2.3 and 2.4)					
Trade Name:		Telephone and extension:					
2.2. NATIONAL SPONSOR: (Previously registered in the INS REPEC)							
RUC:		Company Name: (Data of your legal representative added in numerals 2.3 and 2.4)					
Trade Name:		Telephone and extension:					
Email:							
2.3. LEGAL REPRESENTATIVE (For a company, accredited in the validity of the power / for a public entity, accredited in the Resolution that designates): (If there is a person other than the legal representative as an attorney, he/she must have the special power which must expressly indicate the act(s) to be performed. which was conferred)							
Father's Surname:		Mother's Surname:					
Names:		DNI/ CE/ PAS:					
Power of attorney registered at the Office Registry - SUNARP: (Complete if you are from Lima or province)		Post:					

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Electronic record No.:		Seat No.:	
Resolution number that designates him: (Complete this item only if it is a public entity and detail the full name of the resolution)		Date: (Day, month and year)	
Email:		Telephone and extension:	
2.4. ADDRESS OF THE LEGAL REPRESENTATIVE: If you consider any additional information important, add it.			
Address:		District:	
Province:		Department:	
2.5. OTHERS: If you consider any additional information important, add it.			
TYPE OF INSTITUTION			
II. GENERAL INFORMATION ABOUT THE CLINICAL TRIAL			
Clinical Trial Title: (Enter as shown in the REPEC)			
EC INS No.:		Insurance Policy Expiration Date:	

III. JUSTIFICATION OF THE REASONS FOR THE REQUEST TO CANCELLATE THE CLINICAL TRIAL.	
If you consider any additional information important, you can attach it as an annex.	
The document was attached:	

IV. REQUIREMENTS FOR THE CLINICAL TRIAL CANCELLATION REQUEST	
a Request for cancellation of the clinical trial justifying the reasons for cancellation and describing the data obtained up to that point (FOR-DIIS-042).	<input type="checkbox"/>
b Report on the measures to be taken with the research subjects, if applicable.	<input type="checkbox"/>

V. FIRMA	
I declare that the information provided is true and I authorize the verification of the statements in accordance with the "Principle of Presumption of Truth" of section 1.7 of article IV of the Preliminary Title of the Consolidated Text of Law No. 27444 - General Administrative Procedure Law, approved by Supreme Decree 004-2019-JUS.	
In token of conformity, I sign this document.	
Date ____/____/____ - Time:	
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Name and signature of Legal Representative (item 2.3)	