



NCCTG

NORTH CENTRAL CANCER TREATMENT GROUP

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**Protocol Title:** N0775, A Randomized Phase II Trial of Temozolomide (TMZ) and Avastin® or ABI-007/Carboplatin (CBDCA) and Avastin® in Patients with Unresectable Stage IV Malignant Melanoma

**IRB# (Insert Number)**

**Principal Investigator: (Insert name of treating physician).**

(Date)

*{ Name }  
{ Street Address }  
{ City, State Zip }*

RE: *{ first name } { last name }*  
Patient ID# *(If applicable):*

Dear *{ Mr., Ms, or Mrs. }*

Your relative, \_\_\_\_\_, was involved in a research study about melanoma. We are asking for your permission for use of his/her tumor tissue sample. The tissue sample was collected prior to study treatment and kept in a tumor tissue registry as part of normal clinical procedures through the North Central Cancer Treatment Group (NCCTG). The testing performed on the tissue sample will be done in order to understand how the cancer responded to treatment. It is hoped that this will help investigators better understand melanoma.

Please understand your permission is voluntary. Specifically, your current or future medical care at **(Insert name of treating institution)** will not be jeopardized if you choose not to give permission.

If you have any questions about this research study, please contact your **(Insert Treating Physician name), M.D.** at 1 **(XXX) XXX-XXXX**. If you have any concerns, complaints, or general questions about research or your rights, please contact the **(Insert your IRB name)** Institutional Review Board (IRB) to speak to someone independent of the research team at **(XXX) XXX-XXXX** or toll free (if applicable) at **(XXX) XXX-XXXX**.

If you do not wish to give permission, please indicate on the next page and return this letter since it will make a follow-up telephone call unnecessary. Thank you very much for your time and consideration.

Sincerely,

**(Insert Treating Physician name), M.D.**  
**(Insert appropriate mailing address)**

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**IRB #**

**Principal Investigator:** **(Insert Treating Physician name)**

RE: *{ first name}{ last name}*

Patient ID # *(If applicable):*

I do **not** wish to give permission for use of my relative's, *(name)*, tissue sample for melanoma research.

I **would** like to give permission of my relative's, *(name)*, tissue sample for melanoma research and have read and signed the attached consent form.

I would like more information about this research study before I make my decision. Please call me. *(Please complete the contact information below).*

Your name: \_\_\_\_\_

Telephone number: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

(\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Today's date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Best time to call:  Morning  Afternoon  Evening

Best day(s) to call: \_\_\_\_\_

Thank you!