

SCID COMMERCIAL LICENSE REQUEST FORM

Note: The issuance of a SCID license letter of agreement is required for studies that are in part or wholly funded by commercial entities/for profit organizations. Please complete this form for each license request and e-mail to: SCID4@COLUMBIA.EDU. All section titles highlighted in bold below must be completed.

Also this form is for the request of either the SCID-I Research Version or Clinical Trials Version. The SCID Clinician Version is distributed by American Psychiatric Publishing, Inc. (APPI). The contact information for APPI is 800-368-5777 or www.appi.org.

Protocol Number:
Study Title:
Study Description:
Total Number of Participants to be Screened:
Specify: <input type="checkbox"/> SCID-I-Research Version (RV) <input type="checkbox"/> SCID-I Clinical Trials Version (CT) If SCID-I Clinical Trials Version is requested, enter inclusion criteria/primary psychiatric diagnosis sought: _____
Indicate whether: <input type="checkbox"/> A copy of the SCID (unmodifiable) is to be sent to the e-mail address below. Please note there is a one time charge of \$50 for delivery within the U.S. and \$70 outside the U.S. <input type="checkbox"/> A copy of the SCID in Microsoft Word with modifiable text is to be sent electronically to the e-mail address below. Please note the cost of this Word version is \$250 and a permission form is required. To download, visit www.scid4.org/order/permission/use_scid.html <input type="checkbox"/> A copy of the SCID-I-RV/CT has already been obtained. This is a commercial license request only.

Name of Institution/Organization Funding the Study:		
First and Last Name of Authorized Representative:		
E-mail:	Phone #:	Fax #:
If Different, Enter the First and Last Name of the Person who the SCID is to be delivered to:		
E-mail to be used for SCID distribution if other than authorized representative:	Phone #:	Fax #:
Address 1 Enter complete street address. PO Boxes are not accepted.		
Address 2 Suite/Department/Floor or Other Identifying Information:		
City:	State/Province:	Postal Code:
Enter the First and Last Name of Billing Contact:		
E-mail:	Phone #:	Fax #:
Address 1 Enter complete address information where invoice should be sent, if different than above.		
Address 2 Suite/Department/Floor or Other Identifying Information:		
City:	State/Province:	Postal Code:
If required, include other specific instructions:		