CIBMTR® CENTER FOR INTERNATIONAL BLOOD & MARROW TRANSPLANT RESEARCH

Instructions for Hodgkin's and Non-Hodgkin's Lymphoma Post-HSCT Data (Form 2118)

This section of the CIBMTR Forms Instruction Manual is intended to be a resource for completing the Hodgkin's and Non-Hodgkin's Lymphoma Post-HSCT Data Form.

E-mail comments regarding the content of the CIBMTR Forms Instruction Manual to: CIBMTRFormsManualComments@nmdp.org. Comments will be considered for future manual updates and revisions. For questions that require an immediate response, please contact your transplant center's CIBMTR liaison.

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Instructions for Hodgkin's and Non-Hodgkin's Lymphoma Post-HSCT Data

Hodgkin's lymphoma (HL or Hodgkin's disease) is a cancer of the immune system that is marked by the presence of a type of cell called the Reed-Sternberg cell. The two major types of Hodgkin's lymphoma are classical Hodgkin's lymphoma (90-95% of cases) and nodular lymphocyte-predominant Hodgkin's lymphoma (5-10% of cases).

Classical Hodgkin's lymphoma can be further subdivided into four histologic subtypes: nodular sclerosis (NS), mixed cellularity (MC), lymphocyte deplete (LD), and lymphocyte rich (LR). Symptoms include the painless enlargement of lymph nodes, spleen, or other immune tissue. Generalized pruritus is also common and may precede the diagnosis by months. The most common sites of involvement include cervical, supraclavicular, and mediastinal lymph nodes.

Central nervous system involvement may occur in rare cases. Other symptoms include fever, weight loss, fatigue, and/or night sweats.

Non-Hodgkin's lymphoma (NHL) is a large group of cancers derived from lymphocytes (white blood cells). Non-Hodgkin's lymphomas can occur at any age and are often marked by enlarged lymph nodes, fever, night sweats, and weight loss. There are many different types of non-Hodgkin's lymphoma. These types can be divided into aggressive (fast-growing), intermediate, or indolent (slow-growing) and can develop from either B-cells or T-cells. See Table 1.

Lymphomas that occur after bone marrow or stem cell transplantation are usually B-cell non-Hodgkin's lymphomas and are collectively known as post-transplant lymphoproliferative disorders (PTLD).

Table 1. Types of Non-Hodgkin's Lymphomas

B-cell Neoplasms	T-cell and NK-cell Neoplasms
Burkitt's lymphoma/Burkitt cell leukemia {ALL L3} (111)	Adult T-cell lymphoma/leukemia (HTLV1+) (134)
High-grade B-cell lymphoma, Burkitt-like (provisional entity) (135)	Aggressive NK-cell leukemia (27)
Diffuse large B-cell lymphoma (DLBC) (107) If known, indicate subtype: • Intravascular large B-cell lymphoma (136) • Mediastinal large B cell lymphoma (125) • Primary effusion lymphoma (138) • Diffuse large B-cell lymphoma, subtype unknown	Anaplastic large-cell lymphoma, T/null cell, primary cutaneous type (147)
Extranodal marginal zone B-cell lymphoma of MALT type (122)	Anaplastic large-cell lymphoma, T/null cell, primary systemic type (148)
Follicular lymphoma (includes variants) • Grade I: predominantly small cleaved cell (102) • Grade II: mixed, small cleaved, and large cell (103) • Grade III: predominantly large cell (104) • Unknown: follicular grade (164)	Angioimmunoblastic T-cell lymphoma (AILD) (131)
Lymphoplasmacytic lymphoma (121)	Enteropathy-type T-cell lymphoma (133)
Mantle cell lymphoma (115)	Extranodal NK/T-cell lymphoma, nasal type (137)

Nodal marginal zone B-cell lymphoma (+/– monocytoid B cells) (123)	Hepatosplenic gamma-delta T-cell lymphoma (145)
Primary CNS lymphoma (118)	Mycosis fungoides (141)
Splenic marginal zone B-cell lymphoma (124)	Peripheral T-cell lymphoma {NOS} (130)
Waldenstrom macroglobulinemia (173)	Subcutaneous panniculitis-like T-cell lymphoma (146)
Other B-cell lymphoma (129)	Sezary syndrome (142)
	Large T-cell granular lymphocytic leukemia (126)
	Other T/NK cell lymphoma (139)

This form must be completed for all recipients whose primary disease, reported on Form 2000 question 9, is Hodgkin's Lymphoma (HL). This form should also be completed for all recipients whose primary disease, reported on Form 2000 question 9, is non-Hodgkin's Lymphoma (NHL), with the exception of Waldenstrom macroglobulinemia (MAC). The Hodgkin's and Non-Hodgkin's Lymphoma Post-HSCT Data (Form 2118) must be completed in conjunction with each Post-HSCT follow-up form (Forms 2100, 2200, and 2300) completed. The form is designed to capture specific data occurring within the timeframe of each reporting period (i.e., between day 0 and day 100 for Form 2100; between day 100 and the six-month date of contact for six-month follow-up Form 2200; and between the date of contact for the six-month follow-up Form 2200 and the date of contact for the one-year follow-up Form 2200, etc.).

Key Fields

Accuracy of the Key Fields is essential for ensuring that:

- Data are being reported for the correct recipient.
- Transplant centers have access to their data.
- Data are being shared with the correct donor center, cord blood bank, cooperative registry, or other agency.

For instructions regarding the completion of the Key Fields, see Appendix K. Key fields include all fields listed in the box found in the upper right-hand corner of the first page of the paper form, or on the "key page" in the FormsNet™ 2 application.

Disease Assessment at the Time of Best Response to HSCT

When determining the best response to HSCT in any post-HSCT reporting period (i.e., 100 day, six month, one year, etc.), compare the post-HSCT disease status to the status immediately prior to the preparative regimen (or the disease status at time of pre-HSCT evaluation if no additional therapy was given between the evaluation and the start of preparative regimen). Identify the recipient's best disease status within the reporting period, even if relapse or progression followed the best response. If the best response was achieved in a previous reporting period, report this response again and indicate that it was previously reported.

Question 1: Compared to the disease status prior to the preparative regimen, what was the best response to HSCT since the date of last report?
The intent of this question is to determine the best overall response to HSCT overall. This is assessed in each reporting period. When evaluating the best response, determine the disease status within the reporting period and compare it to all previous post-HSCT reporting periods. If the response in the current reporting period is the best response to date, report the disease status established within this reporting period. If a better response was established in a previous reporting period, report the previously established disease status. See question 2 to indicate that this disease status was previously reported.

NOTE:
Only report the best response to HSCT from all reporting periods.

Example 1. If a recipient with lymphoma goes to transplant having established a PR prior to transplant, achieved a CR during the first 100 days, and then relapses during the six-month reporting period, the best response to transplant should be reported as "CR" on all subsequent forms. See below:

Reporting Period	Disease Status	Q1. Best Response To HSCT	Q2. Date the best response first began
Pre-transplant	PR	---	---
100-Days Post-HSCT	CR	CR	*[date of scan]*
6-Months Post-HSCT	Relapsed	CR	Previously reported
1-Year Post-HSCT	PR	CR	Previously reported

Example 2. A recipient with lymphoma goes to transplant having established a CR prior to transplant and maintains the response after transplant, then relapses within the six-month reporting period. The best response to transplant would be reported as "CCR" for all subsequent reporting periods. See below:

Reporting Period	Disease Status	Q1. Best Response To HSCT	Q2. Date the best response first began
Pre-transplant	CR	---	---
100-Days Post-HSCT	CR	CCR	*[date of scan that first confirmed a continued CR]*
6-Months Post-HSCT	Relapsed	CCR	Previously reported
1-Year Post-HSCT	PR	CCR	Previously reported

Example 3. A recipient with lymphoma goes to transplant having established a PR prior to transplant and maintains the response throughout the 100-day reporting period. During the six-month reporting period, the recipient progresses and begins unplanned therapy to treat the worsening disease. During the 1-year reporting period, the recipient achieves another CR. The best response to transplant occurred during the 100-day reporting period because response to unplanned therapy is not captured using this set of questions. See below:

Reporting Period	Disease Status	Q1. Best Response To HSCT	Q2. Date the best response first began
Pre-transplant	PR	---	---
100-Days Post-HSCT	PR	PR	*[date of scan that first confirmed a continued PR]*
6-Months Post-HSCT	Relapsed	PR	Previously reported
1-Year Post-HSCT	CR	PR	Previously reported

Include response to any post-HSCT treatment planned as of Day 0. If post-transplant therapy is given as prophylaxis or maintenance for recipients in CR or as preemptive therapy for recipients with minimal residual disease, consider this "planned therapy," even if this was not documented prior to the transplant. ***Do not include any treatment administered as a result of relapse or progression.***

Question 2: Date best response first began
Enter the date the best response first began. Report the date the CT, MRI, PET, or PET/CT scan was obtained.

If the best response is the same as the pre-transplant disease status, report the date of the first radiological assessment that confirmed the ongoing disease status or "previously reported" if the date was already reported on a previous form. See examples 2 and 3 above.

If the date was reported in a prior period, check "date previously reported" and continue with question 6.

Laboratory Studies at the Time of Best Response to HSCT

Question 3: Was molecular testing performed at the time of best response to HSCT (reported in questions 1-2)?
Molecular assessment involves determining whether a molecular marker for the disease exists. Molecular assessment is the most sensitive method of detection, and can indicate known genetic abnormalities (e.g., immunoglobulin (Ig) or T-cell receptor gene rearrangements, or other specific lymphoma gene rearrangements). PCR testing is an example of a molecular test method.

If molecular testing was performed at the time of the best response to HSCT, indicate "yes" and continue with question 4. If molecular testing was not performed at the time of the best response to HSCT, indicate "no" and continue with question 6.

Question 4: Specify the date molecular testing was performed
If molecular evaluations were performed at the time of best response, report the test date. If the exact date is not known, use the process described for reporting partial or unknown dates in General Instructions, Guidelines for Completing Forms.

Question 5: Was disease detected?
If a molecular marker associated with the recipient's disease was detected at the time of best response, indicate "yes." See Table 2 for common molecular markers associated with different lymphomas.

If no molecular marker associated with the recipient's disease was identified at the time of best response, indicate "no."

Table 2.

Oncogene	Protein	Translocation	Disease
bcl-1	Cyclin D_1	t(11;14)	MCL
bcl-2	BCL-2 (antiapoptosis)	t(14;18)	FL, some DLBCL
bcl-3	NF-kB inhibitor	t(11;19)	CLL
myc	Transcription factor	t(8;14)	Burkitt's NHL
bcl-6	Zinc-finger transcription factor	t(3;14)	DLBCL (some follicular NHL)

National Comprehensive Cancer Network. *Practice Guidelines in Oncology*. v1. 2006.

Post-HSCT Planned Treatment for Lymphoma

Question 6: Was planned treatment given per protocol since the date of the last report?
Indicate if the recipient received planned treatment post-HSCT since the date of last report. If “yes,” continue with question 7. If “no” or “not known,” continue with question 22.

Recipients are generally transplanted under a specific protocol that defines the radiation and/or systemic therapy the recipient is intended to receive as a preparative regimen prior to the HSCT; infection and GVHD prophylaxis to be administered pre and/or post HSCT; as well as any systemic therapy, radiation, and/or other treatments to be administered post HSCT as planned (or maintenance) therapy. Planned (maintenance or consolidation) therapy is given to assist in prolonging a remission. This protocol may be either a research protocol or standard of care protocol and should be referred to when completing this section.

Additionally, if post-transplant therapy is given as prophylaxis or maintenance for recipients in CR or as preemptive therapy for recipients with minimal residual disease, consider this “planned therapy," even if this was not documented prior to the transplant. Do not include any treatment administered as a result of relapse or progression.

Question 7: Specify planned treatment given: Chemotherapy
Indicate if chemotherapy was given as planned treatment post-HSCT since the date of the last report. If chemotherapy was not given as planned therapy, then indicate “No.”

Post-transplant therapy given as prophylaxis or maintenance for recipients in CR or as preemptive therapy for recipients with minimal residual disease should be reported here, even if this was not documented prior to transplant. For example, if a physician decides to put the recipient on bortezomib and vorinostat **maintenance** therapy post-HSCT, even if it the intent was not documented prior to transplant, report it here.

Rituximab and other immune therapy/monoclonal antibodies should be reported on question 12.

Do not report chemotherapy given for relapse or progressive disease.

Question 8: Specify planned treatment given: Radiation
Radiation therapy uses high-energy radiation to kill cancer cells. For lymphoma, external-beam radiation is the type used most frequently. In this method, a beam

of radiation is delivered to a specific part of the body such as the mediastinum. Radiation may be planned if bulky (having a large lymph node mass) disease was present just prior to transplant.

Indicate if the recipient received radiation as planned therapy post-transplant since the date of the last report. If "Yes," continue with question 9. If "No," continue with question 12.

Questions 9-11: Specify radiation site(s)
Indicate if the mediastinum or another site received radiation treatment. If "Other site," specify area on question 11.

Question 12: Specify planned treatment given: immune therapy/ monoclonal antibody (mAb)
Indicate if immune therapy/monoclonal antibody (mAb) was given as planned treatment post-HSCT since the date of the last report. If immune therapy/monoclonal antibody (mAb) was not given as planned therapy, then indicate "No."

Post-transplant therapy given as prophylaxis or maintenance for recipients in CR, or as preemptive therapy for recipients with minimal residual disease, should be reported here, even if this was not documented prior to transplant. For example, if a physician decides to put the recipient on rituximab **maintenance** therapy post-HSCT, even if it the intent wasn't documented prior to transplant, report it here.

Questions 13-19: Specify therapy given
Indicate "yes" or "no" for each of the immune therapy agents/monoclonal antibodies listed. If "Other mAb," indicate the generic name in question 17. If "Other immune therapy," indicate the generic name in question 19.

Question 20: Specify planned treatment given: Other treatment
Indicate if a treatment not already listed was given as post-transplant planned therapy. If "Yes," continue with question 21. If "No," continue with question 22.

Question 21: Specify planned treatment
Indicate the name of other planned treatment not included in questions 7-19.

Question 22: Was a disease relapse or progression detected by any method since the date of the last report?
Use the table below to determine if a relapse or progression occurred since the date of the last report. These criteria relate specifically to clinical/hematologic relapse or progression detected in nodal or extranodal sites (spleen, marrow, skin, etc.) Do not report new or recurrent molecular, cytogenetic, or FISH abnormalities as evidence of relapse or progression without evidence of

nodal/extranodal relapse or progression. Questions 40-45 are meant to capture the recipient's molecular and FISH status *at the time of* nodal/extranodal relapse or progression.

Table 3.

Disease Status	Definition
Relapse (Rel)	Recurrence of disease following CR, which may involve an increase in size of known disease or new sites of disease.
Progression (PD)	An increase in size of known disease or new sites of disease.

Each occurrence of relapse should be reported (unlike on the TED-track forms). Indicate "yes" if a relapse or progression occurred during this reporting period and continue with question 23. Indicate "no" if the recipient did not relapse or progress this reporting period and continue with question 49.

Question 23: Specify the total number of nodal sites involved
Lymph node regions or groups occur above and below the diaphragm. Nodal regions include cervical (neck), axillary, mediastinal (thoracic), mesenteric (abdominal), para-aortic (pelvic), inguinal, epitrochlear, and popliteal. Indicate the total number of nodal regions with evidence of lymphoma involvement.

Question 24: Was there any known extranodal or splenic involvement since the date of the last report?
Extranodal refers to the presentation of lymphoma outside of the lymph nodes. Common areas of extranodal involvement may include bone, gastrointestinal tract, and skin. Splenic involvement in lymphoma is also common. It is usually evidenced by enlargement of the spleen, or splenomegaly. Splenic or other extranodal involvement is most often detected using imaging techniques or pathological findings.

If extranodal involvement was identified since the date of the last report, indicate "yes" and complete questions 25-39. If no extranodal involvement was identified or if evidence of extranodal involvement is unknown since the date of last report, indicate "no" or "unknown" and continue with question 40.

Questions 25-39:
Answer each question "yes" or "no." Do not leave any question unanswered. If "Other site," specify using question 39.

Question 40: Specify the method(s) of disease assessment and results at the time of disease relapse or progression: Molecular assessment
Molecular assessment involves determining whether a molecular marker for the disease exists. Molecular assessment is the most sensitive method of detection, and can indicate known genetic abnormalities (e.g., immunoglobulin (Ig) or T-cell

receptor gene rearrangements, or other specific lymphoma gene rearrangements). PCR testing is an example of a molecular test method.

If a molecular assessment was performed at the time of the nodal/extranodal relapse or progression, indicate “yes” and continue with question 41.

If a molecular assessment was not performed at the time of relapse or progression, indicate “no” and continue with question 43.

Question 41: Date of molecular assessment
Enter the date that the sample was collected for molecular assessment. If multiple molecular assessments were performed during the reporting period, report the first molecular assessment that detected relapse.

If the exact date is not known, use the process described for reporting partial or unknown dates in General Instructions, Guidelines for Completing Forms.

Question 42: Was disease detected?
If a molecular marker associated with the recipient’s disease was detected at the time of relapse or progression, indicate “yes.” See Table 2 above for common molecular markers associated with different lymphomas.

If no molecular marker associated with the recipient’s disease was identified at the time of relapse or progression indicate “no.”

Question 43: Specify the method(s) of disease assessment and results at the time of disease relapse or progression: Cytogenetic assessment by FISH
Fluorescence in situ hybridization (FISH) is a sensitive technique that assesses a large number of cells. Although often used for finding specific features in DNA, FISH is not as sensitive as molecular methods, even though the markers identified may be the same. This technique utilizes special probes which recognize and bind to fragments of DNA that may be found in lymphomas. These probes are mixed with cells from the recipient’s blood. A fluorescent “tag” is then used to visualize the binding of the probe to the disease cells. FISH is capable of detecting disease in 1 in 1,000 cells. Examples include t(11;14) or t(14;18).

FISH testing for sex chromosomes after sex-mismatched allogeneic HST should not be considered disease assessment, as the purpose is to determine donor chimerism.

If cytogenetic assessment by FISH testing was performed at the time of nodal/extranodal relapse or progression, indicate “Yes” and continue with question 44.

If cytogenetic assessment by FISH testing was not performed at the time of relapse or progression, indicate “No” and continue with question 46.

Question 44: Date of FISH assessment
Enter the date that the sample was collected for FISH assessment. If multiple FISH assessments were performed during the reporting period, report the first FISH assessment that detected relapse.

If the exact date is not known, use the process described for reporting partial or unknown dates in General Instructions, Guidelines for Completing Forms**.**

Question 45: Was disease detected?
If a marker associated with the recipient’s disease was detected at the time of relapse or progression, indicate “Yes.”

If no marker associated with the recipient’s disease was identified at the time of relapse or progression indicate “No.”

Question 46: Specify the method(s) of disease assessment and results at the time of disease relapse or progression: Clinical/Hematologic assessment
Clinical and hematologic techniques are the least sensitive for detecting evidence of disease. Clinical/hematologic methods used to evaluate disease relapse or progression for HL/NHL include radiological assessments (e.g., CT, MRI, PET, or PET/CT scans) or a physician may determine relapse based on a clinical assessment (i.e., physical exam) at an office visit.

If a clinical/hematologic assessment was performed at the time of the relapse or progression, indicate “yes” and continue with question 47.

Question 47: Date of Clinical/hematologic assessment
Enter the date of the clinical/hematologic disease assessment that documented disease relapse or progression. Report the date disease was detected by radiographic examination (e.g., CT, MRI, PET, or PET/CT scans). If a radiographic assessment was not performed, report the office visit in which the physician clinically documented the disease relapse or progression.

For more information regarding reporting partial or unknown dates, see General Instructions, Guidelines for Completing Forms.

Question 48: Was disease detected?
If evidence of disease was detected at the time of relapse or progression by clinical/hematologic assessment, indicate “Yes.”

If no evidence of disease was detected at the time of relapse or progression by clinical/hematologic assessment, indicate “No.”

Question 49: Was a positron emission tomography (PET) scan performed since the date of the last report?
Positron Emission Tomography (PET) is a type of nuclear medicine imaging in which a patient receives a small amount of radioactively labeled sugar. Because cancer cells absorb sugar more avidly than other cells of the body, the radioactive labeled sugar accumulates in these areas revealing tumors as bright spots. If a PET or (PET/CT) scan was performed since the date of the last report, indicate "yes" and continue with question 50. If a PET scan was not performed since the date of last report, indicate "no" and continue with question 53.

Question 50: Date of most recent PET scan
If multiple PET scans were performed during the reporting period, use the PET scan results closest to end of the reporting period. Enter the date the most recent PET (or PET/CT) scan was performed.

For more information regarding reporting partial or unknown dates, see General Instructions, Guidelines for Completing Forms.

Question 51: Results of most recent PET scan
Indicate "positive" if the PET scan showed areas of avid uptake consistent with tumor (i.e., lymphoma). Indicate "negative" if the PET scan did not show areas of avid uptake consistent with tumor. If the results of the scan cannot be determined, and are not clearly positive or negative, select "indeterminate/equivocal."

Question 52: Was the positive result considered a disease recurrence or progression?
If the PET (or PET/CT) scan was positive, indicate "yes" if it detected a disease recurrence or progression.

Disease Status at the Time of Assessment for This Reporting Period

Question 53: Was the current disease status assessed by molecular testing?
Molecular assessment involves determining whether a molecular marker for the disease exists. Molecular assessment is the most sensitive method of detection, and can indicate known genetic abnormalities (e.g., immunoglobulin (Ig) or T-cell receptor gene rearrangements, or other specific lymphoma gene rearrangements). PCR testing is an example of a molecular test method.

If a molecular assessment was performed during this reporting period, indicate "yes" and continue with question 54.

If a molecular assessment was not performed during this reporting period, indicate “no” and continue with question 56.

Question 54: Date of most recent molecular assessment
Enter the date that the sample was collected for molecular assessment. If multiple molecular assessments were performed during the reporting period, report the most recent molecular assessment.

If the exact date is not known, use the process described for reporting partial or unknown dates in General Instructions, Guidelines for Completing Forms**.**

Question 55: Was disease detected?
If a molecular marker associated with lymphoma was detected at the time of assessment, indicate “yes.” See Table 2 above for common molecular markers associated with different lymphomas.

If no molecular marker was identified at the time of assessment, indicate “no.”

Question 56: Was the current disease status assessed by conventional cytogenetics/FISH?
Cytogenetic assessment involves testing blood or bone marrow for the presence of a known cytogenetic abnormality (e.g., t(11;14); t(14;18)) that reflects the recipient’s disease

Fluorescence in situ hybridization (FISH) is a sensitive technique that assesses a large number of cells. Although often used for finding specific features in DNA, FISH is not as sensitive as molecular methods, even though the markers identified may be the same. This technique utilizes special probes which recognize and bind to fragments of DNA that may be found in lymphomas. These probes are mixed with cells from the recipient’s blood. A fluorescent “tag” is then used to visualize the binding of the probe to the disease cells. FISH is capable of detecting disease in 1 in 1,000 cells. Examples include t(11;14) or t(14;18).

FISH testing for sex chromosomes after sex-mismatched allogeneic HST should not be considered disease assessment, as the purpose is to determine donor chimerism.

If cytogenetic/FISH assessment was performed during the reporting period, indicate “Yes” and continue with question 57.

If cytogenetic/FISH testing was not performed during the reporting period, indicate “No” and continue with question 59.

Question 57: Date of most recent cytogenetic/FISH assessment
Enter the date that the sample was collected for cytogenetic/FISH assessment. If multiple cytogenetic/FISH assessments were performed during the reporting period, report the most recent cytogenetic/FISH assessment.

If the exact date is not known, use the process described for reporting partial or unknown dates in General Instructions, Guidelines for Completing Forms**.**

Question 58: Was disease detected?
If a cytogenetic abnormality or marker associated with the recipient's disease was detected at the time of assessment, indicate "Yes."

If no cytogenetic abnormality or marker associated with the recipient's disease was identified at the time of assessment, indicate "No."

Question 59: What is the current disease status?
Indicate if the recipient is in a complete remission or not. Complete remission (CR) is the complete disappearance of all known sites of disease for >4 weeks. CR undetermined (CRU) is the complete disappearance of all known sites of disease with the exception of persistent scan abnormalities of unknown significance. CRU should be reported as "complete remission." Molecular or cytogenetic evidence of disease should **not** be considered when answering this question.

Question 60: Date the current disease status was established in this reporting period
Enter the date of the most recent assessment of disease status for this reporting period. Report the date imaging (CT, MRI, PET, or PET/CT) took place. If no radiographic assessment was performed, report the date of the most recent office visit in which the physician assessed the recipient's disease status.

If the exact date is not known, use the process described for reporting partial or unknown dates in General Instructions, Guidelines for Completing Forms.

Question 61: Signed
The person completing the form must sign the form, print his/her name, and provide a phone number, fax number, and e-mail address where he/she can be reached.