ERROR CORRECTION FORM

Sequence Number: | CIBMTR Recipient ID: | Initials:

Today's Date: Month Day 20 Year | Infusion Date: Month Day 20 Year | CIBMTR Center Number:

Form 2564 R1.0: Sanofi Eligibility

Center: CRID:

Key Fields

Sequence Number: _____

Date Received: __ __ __ __ - __ __- __ __

CIBMTR Center Number: _____

CIBMTR Research ID: _____

Event date: __ __ __ __ - __ __- __ __

Sanofi Eligibility Criteria

Questions: 1 - 2

1 Did the HCT occur ≤ 12 months from start of initial therapy for myeloma?

- ○ Yes
- ○ No (HCT occurred > 12 months from start of initial therapy for myeloma)

2 Did the recipient have associated light chain (AL) amyloidosis?

- ○ Yes ○ No

First Name: _____

Last Name: _____

E-mail address: _____

Date: __ __ __ __ - __ __- __ __

Mail, fax or email this form to Minneapolis. Fax: 612-627-5895. Email: scanform@nmdp.org.
Retain the original form at the transplant center.