# SCID COMMERCIAL LICENSE REQUEST FORM

**Note: The issuance of a SCID commercial license 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.**

**Date of Request:**

**Protocol Number:**

**Study Title:**

**Study Description:**

**Total Number of Participants to be Screened:**

**Specify:**

☐ SCID-I-Research Version (RV)

☐ SCID-I Clinical Trials Version (CT)

If SCID-I Clinical Trials Version is requested, enter inclusion criteria/primary psychiatric diagnosis sought:

_____

**Indicate whether:**

☐ A copy of the SCID-RV (unmodifiable) is to be sent to the e-mail address below. Please note there is a one time charge of $50.

☐ A copy of the SCID-RV 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

☐ A fee of $1,500 applies for the development of the SCID-CT only, i.e., not SCID-RV, for trials with less than 200 subjects.

☐ This is a commercial license request only.
[ ] A copy of the SCID-I-RV has already been obtained.
[ ] A copy of the SCID-I-CT has already been obtained.

| | | |
|---|---|---|
| **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: |

**Select Method of Payment:**

☐ Check mailed to Biometrics Research at Columbia University
1051 Riverside Dr, Box 60, NY, NY 10032

☐ Credit Card (Visa, Master Card or American Express cards accepted)

If required, include other specific instructions, i.e., including a purchase order number on the invoice, etc.