Statement of Education and Qualifications

PLEASE PRINT OR TYPE THE FOLLOWING INFORMATION:

Name (First, Middle, Last)	**Academic Qualification(s)** (e.g. MD, MBBS, Medical License Number, etc)
Kamil Damaz	Study Coordinator

Address (Name of Institution, Street, City, Postal Code, State or Province (if applicable), Country)

Centrum Medyczne Euromed Sp. z o.o.
ul. Próchnika 30/5
90-715 Łódź, Poland

Telephone Number (Country Code, Area Code, Number)	**FAX Number** (Country Code, Area Code, Number)
48513782513	

Education and Training (List all Colleges, Universities and Medical Schools attended incl. postdoctoral/fellowship training, including board certification/medical license)

Name and Location of Institution (City, State or Province and Country)	Degree and Year Awarded	Area of Study
University of Lodz	2013	Lodz

Professional Experience

Position/Title	Name and Location of Institution (City, State or Province and Country)	Dates (Start/Stop Dates as applicable)
Study Coordinator	Centrum Medyczne Euromed, 90-715 Lodz, Próchnika 30/5, Poland	2013

Previous participation in clinical trials (Required Information for Investigators in the European Union)

Indication of Trial	Clinical Phase of Trial (I-IV)	Role in Trial (e.g. Investigator, Sub-Investigator)	Year in which trial was conducted
protocol No VEN307-AF-001	III	Study Coordinator	2013

Training on ICH/GCP: YES X If yes, specify below NO ☐

GCP training 2013

Other documents evidencing experience or expertise attached: YES ☐ If yes, specify below NO X

Signature (if required)	**Date**
Kamil Doman	21 JUL 2014