

### 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
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**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
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**Telephone Number (Country Code, Area Code, Number)**

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

48513782513	
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**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

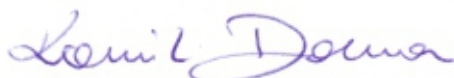
Training on ICH/GCP: YES  If yes, specify below NO 

GCP training 2013

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

Signature (if required)

Date

	21 JUL 2014
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