

Name: DR. ARUNARYA RAVEENDRAN

Main/Daytime

Evening:

Company/Institution Name: TATA MEDICAL CENTRE

Cell/Mo +91 7406110372

Address: KOLKATA, INDIA

bile:

Fax:

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#### Affiliations

| Facility Name (Department Name) | Facility Address              | Department Address |
|---------------------------------|-------------------------------|--------------------|
| RADIATION ONCOLOGY              | TATA MEDICAL CENTRE NEW TOWN, | KOLKATA            |
|                                 |                               |                    |
|                                 |                               |                    |
|                                 |                               |                    |
|                                 |                               |                    |
|                                 |                               |                    |
|                                 |                               |                    |

#### Education (Add more rows if needed.)

| Institution                         | Degree/Certificate | Specialty          | Year Completed |
|-------------------------------------|--------------------|--------------------|----------------|
| KASTURBA MEDICAL COLLEGE, MANGALORE | MBBS               | -                  | 2019           |
| SRI RAMACHANDRA MEDICAL COLLEGE     | M.D.               | RADIATION ONCOLOGY | 2025           |

#### Professional Experience

| Job Title                | Institution                              | Year Started | Year Completed |
|--------------------------|------------------------------------------|--------------|----------------|
| INTERN                   | KASTURBA MEDICAL COLLEGE, MANGALORE      | 2019         | 2020           |
| RESIDENT MEDICAL OFFICER | PNMA MEMORIAL HOSPITAL, MALAPPURAM       | 2020         | 2020           |
| JUNIOR RESIDENT          | SRI RAMACHANDRA MEDICAL COLLEGE, CHENNAI |              |                |

#### License Details (Add more rows if needed.)

| Type of License | License Issuer             | Professional License Number | Country | State/Province/Region | Expiration Date |
|-----------------|----------------------------|-----------------------------|---------|-----------------------|-----------------|
| MEDICAL         | TAMIL NADU MEDICAL COUNCIL | 164304                      | INDIA   | TAMIL NADU            | 05.03.2020      |
|                 |                            |                             |         |                       |                 |
|                 |                            |                             |         |                       |                 |
|                 |                            |                             |         |                       |                 |
|                 |                            |                             |         |                       |                 |

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## Research Experience

### Study Type

- ☒ Academic ☐ Government ☐ Industry ☐ Investigator-Initiated
- ☐ Other / Please Specify:

## Clinical Study Phases

- ☐ Phase I ☐ Phase II ☐ Phase III ☐ Phase IV

## Therapeutic Area of Expertise

| Therapeutic Area     | Sub-Therapeutic Area |
|----------------------|----------------------|
| - RADIATION ONCOLOGY |                      |
| - CLINICAL ONCOLOGY  |                      |
|                      |                      |
|                      |                      |

## Relevant Clinical Research Experience

| Role | Therapeutic Area   | Sub-Therapeutic Area | Status   | Year Started | Year Completed | Type of Trial | Phase |
|------|--------------------|----------------------|----------|--------------|----------------|---------------|-------|
| PI   | RADIATION ONCOLOGY |                      | complete | 2023         | 2024           | Retrospective | I     |
|      |                    |                      |          |              |                |               |       |
|      |                    |                      |          |              |                |               |       |
|      |                    |                      |          |              |                |               |       |
|      |                    |                      |          |              |                |               |       |
|      |                    |                      |          |              |                |               |       |
|      |                    |                      |          |              |                |               |       |
|      |                    |                      |          |              |                |               |       |
|      |                    |                      |          |              |                |               |       |

## GCP Training Details

| Course Provider | Course Title   | Date Completed (DD-MMM-YYYY) | Status |
|-----------------|----------------|------------------------------|--------|
| NDA             | CLINICAL TRIAL | 13.06.25                     | PASSED |
|                 |                |                              |        |
|                 |                |                              |        |

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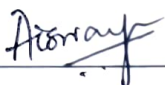
Email

Fax:

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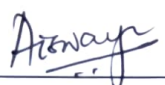
SIGNATURE (Please follow the direction of the Sponsor in completing these fields.)

By signing this form, I confirm that the information provided on this Abbreviated CV is accurate and reflects my current employment and qualifications:

Signature 

Date: 25.06.2025

I hereby declare that I am familiar with the legislation relevant to the conduct of clinical trials and I will comply with their provisions.

Signature 

Date: 25.06.2025.