This form needs to be uploaded into e-prost under Study-Related Documents Section.

**STUDY INFORMATION:**

|  |  |
| --- | --- |
| **Institutional Review Board (IRB)#** |  |
| **Full Title of Study:** |  |
| **PI Name (Last, First):*** **Office #:**
* **Cell (recommended)**
* **Email Address:**
 |  |
| **PI has privileges to perform the study at UHT** | [ ]  Yes [ ]  No  |
|  **Study Coordinator Name (Last, First):*** **Office #:**
* **Cell (recommended)**
* **E-Mail Address:**
 |  |

**STUDY DETAILS**

|  |  |
| --- | --- |
| **Study Type** | [ ]  DRUG [ ]  DEVICE [ ]  BIOLOGIC [ ]  OBSERVATIONAL |
| **Name (s) of Drugs or Devices being investigated (if applicable)** | [ ]  N/A |
| **Funding Source** | [ ]  Industry Sponsored [ ]  Non-Industry Sponsored  |
| **Sponsor Name** |  |
| **Does this study involve an IND(Investigational New Drug)/IDE (Investigational Device Exemption)?** |  [ ]  Yes [ ]  NO IND/IDE No. \_\_\_\_\_\_\_\_\_\_\_ |
| **If Yes,please provide the following IND / IDE information.** | [ ]  Investigator’s Brochure/Product Labeling[ ]  Sponsor Reimbursement Package |
| **Are these products FDA approved?**  | [ ]  Yes [ ]  NO  |
| **Who will provide the investigational product (drug, device)?** | [ ] Manufacturer [ ] Sponsor [ ] Other (please specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Where will the drug/device/agent be stored?** | Location:[ ]  N/A |

|  |  |
| --- | --- |
| **Protocol Start Date** |   |
| **Protocol End Date** |  |
| **Department Name:** |  |
| **Study Activities Location/s at UHealth Tower** |  |
| **Study Activities Description (example: consenting, sample/tissue collection, drug administration, tests, subject interventions, measurements…etc)**  |  |

**UHT CLINICAL SERVICES/RESOURCES REQUIRE** (Check services needed for study) **Or N/A** [ ]

[ ]  **Nutrition Services** (i.e. food, education, etc.)

[ ]  **Pharmacy** (i.e. storage, dispensing, temperature)

Please specify:

[ ]   **Nursing services** (i.e. vital signs, medication administration, urine collection, etc.)

Please specify:

[ ]  **Radiology** (CT Scan, MRI, Ultrasound, etc.)

Please specify:

[ ]  **Cardiology** (EKG, ECHO, etc.,)

Please specify:

[ ]  **Pathology/Laboratory** (phlebotomy, specimen processing... etc.)

Please specify:

[ ]  **Cath Lab**

[ ]  **Other services**

Please specify:

[ ]  **Comments**:

**If you have any questions or concerns please contact us via email:** UHTresearch@miami.edu **or**

 **telephone # 305- 243-1488 (Christopher Otero)**