APPLICATION
FOR RESEARCH ETHICS COMMITTEE
REVIEW OF RESEARCH PROJECT

(SHORT FORM – APPROVED BY OTHER RESEARCH ETHICS BOARD)

A. GENERAL INFORMATION:

PRINCIPAL INVESTIGATOR(S)

Name	Signature
Dept./Div.	Position
Email Address	Telephone Number (include area code & ext.)

CO-INVESTIGATOR (BCHS)

Name	Signature
Dept./Div.	Position
Email Address	Telephone Number (include area code & ext.)

STUDY CO-ORDINATOR

Name	Signature
Dept./Div.	Position
Email Address	Telephone Number (include area code & ext.)

B. DETAILS OF PROJECT:

1. Project Title _____

2. Brief Summary (purpose and/or rationale of proposed research)

3. Proposed Number of Research Subjects _____

4. Expected Start Date of Study: _____

5. Expected Completion Date of Study: _____

6. Is this project funded? __ Yes __ No

7. Sponsor _____

NOTE: *Applications for projects which are sponsored by external agencies (e.g. pharmaceutical companies or other commercial bodies),* ***require a submission fee of $1,500 payable to the BCHS, upon submission of this application.*** *Further fees of $100 - $200 may be charged for amendments and renewals to such studies.*

8. Duration of Funding: from ____/____/____ to ____/____/____

9. Funding Details:

C. WORKLOAD/FINANCIAL IMPACT TO THIS FACILITY

1. Identify the services that will be impacted by this research study:
   - ❑ Laboratory ❑ Pharmacy
   - ❑ Health Records ❑ Other Services: (please specify: _____)

2. **Laboratory Tests:**
   (a) Does this study involve laboratory tests? ❍ YES ❍ NO
   (b) Where will they be performed and at whose expense?
   (c) What is the amount of expense that this will incur on the Laboratory Department?

If the answer to 2(a) is YES, please obtain signature from the Director Diagnostic Imaging, Laboratory Medicine and Pharmacy.

Signature: _____ Date: _____
Printed Name: _____

3. **Health Records:**
   (a) Will you require access to patient personal health information through the Health Records Department?
   ❍ YES ❍ NO
   (b) Will you require assistance in identifying your research population?
   ❍ YES ❍ NO
   (c) Will you require statistics from Health Records for your project?
   ❍ YES ❍ NO

If the answer to 3(a, b or c) is YES, please obtain signature from the Director Health Information Management, System Wide Admission and Discharge, and Infection Control.

Signature: _____ Date: _____
Printed Name: _____

4. **Pharmacy**
   (a) Does this study involve drugs and/or pharmacy services?
   ❍ YES ❍ NO
   (b) If yes, what expenses will this incur for the Pharmacy Department?

If the answer to 4(a) is YES, please obtain signature of Director Diagnostic Imaging, Laboratory Medicine and Pharmacy.

Signature: _____ Date: _____
Printed Name: _____

5. **Diagnostic Imaging**
   (a) Does this study involve Diagnostic Imaging Department?
   ❍ YES ❍ NO
   (c) If yes, what expenses will this incur for the DI Department?

If the answer to 5(a) is YES, please obtain signature of the Director Diagnostic Imaging, Laboratory Medicine and Pharmacy.

Signature: _____ Date: _____
Printed Name: _____

6. **Space:**
   Will this study impact on utilization of space within the hospital?

D. ENCLOSURES REQUIRED:

1. Copy of complete study
2. Copy of Consent Form and other material to be given to patient participants (with the BCHS logo)
3. Copy of the letter of approval from the University Research Committee or Review Board or other academic affiliate