SYNERGY CLINICAL RESEARCH UNIT

Request Help Form

Principal Investigator:
Name: 
Dept: 
Telephone: 
Email: 

Study Coordinator:
Name: 
Dept: 
Telephone: 
Email: 

Study Coordinator:
Name: 
Dept: 
Telephone: 
Email: 

Study Title:

Is this study investigator-initiated ____ or industry-initiated ____?

Sponsor/Funding Source: ________________________________

For each of the services below, please circle Yes (Y) or No (N) to indicate those you are requesting:

Study Preparation and Oversight:
Y  N  Price quotes for CRU services for inclusion in study budgets.
    (Our cost structure is based on funding mechanism and is supportive of investigator-initiated studies.)

Y  N  Coordination with the Clinical Trials Office during budget negotiation
Y  N  Preparation and submission of applications/amendments to the Committee for the Protection of Human Subjects (CPHS)

Y  N  Maintenance of all regulatory documents for site-visits, audits etc.

If you have not requested all of the above services, please indicate who will be responsible for these items: ________________________________

Y  N  Research Nursing assistance

If yes, please briefly describe your estimated need for Research Nursing services (including number of visits per subject).

Y  N  Research Coordinator assistance

If yes, please briefly describe your estimated need for Research Coordinator services (including number of visits per subject).

Y  N  Sample Processing/Storage Services

If yes, please describe.

Y  N  CRU Space on Faulkner 4M

Please indicate date(s)/visit(s) and amount of time requested.

Thank you for your interest in the SYNERGY Clinical Research Unit. We will be in touch with you promptly to review your request. Please let us know if there are services you need that are not listed on this form.