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| **Checklist for Study Submission:** | |
| Abbreviated Research Study Proposal Form (this form) | Attached to email submission to research@tgh.org |
| Study Protocol | Choose an item. |
| PI CV (signed and dated within last 3 years) | Choose an item. |
| Informed Consent Form | Choose an item. |
| Investigator Brochure | Choose an item. |
| TGH Drug Information Sheet | Choose an item. |
| FDA IND Approval Letter | Choose an item. |
| Pharmacy Manual | Choose an item. |

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| **GENERAL INFORMATION** | |
| **Full Study Title:** | Enter Study Title. |
| **Study Protocol Number:** | Enter PROTOCOL ID or USF IRB Study ID. |
| **IRB of Record:** | Select IRB from the list or enter name |
| **IRB #:** | Enter IRB # or make a selection |
| [**NCT #**](http://www.clinicaltrials.gov/)**:** | Enter NCT# or make a selection |
| **Funding:** | Please select a funding source from the list |
| **Sponsor Name:** | Enter Sponsor Name.  Not applicable |
| **Contracted Research Organization (CRO):** | Enter CRO Name.  Not applicable |
| **PI Information** | |
| Principal Investigator (PI) Name: | Enter PI Name |
| Affiliation and Department: | Enter PI Employer and Department or Service Line. |
| Email: | Enter PI email. |
| Cell Phone: | Enter PI Phone Number. |
| Credentialed at TGH? | Choose an item. |
| **Submitter or Primary Contact** | |
| Name: | Enter Submitter or Primary Contact Name. |
| Cell Phone or Telephone: | Enter Submitter or Primary Contact Phone Number. |
| Email: | Enter Submitter or Primary Contact Email Address |
| **Number of planned subjects:** | Enter the # of patient to be enrolled at your site. |
| **Investigational Pharmacy Services Needed** | Storage  Randomization  Drug Preparation/Dispensation  After Hours Dispensation Needed; if yes, select:  Nights Weekends  Order Set Development |
| **Where will the treatment be administered?** | Enter Location |
| **What is the length of time allowed per protocol from time of consent to time of IP administration?** | Enter time |
| **Provide a list of study team members who will be responsible for IP pick up from the pharmacy and transport to site of IP administration.** |  |

**Submitter Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Thank you for your interest in performing/conducting your research project/study at Tampa General Hospital (TGH).