# **Research Study Proposal Form**

**ALL NEW AND ONGOING RESEARCH PROJECT UPDATES MUST BE SUBMITTED TO** [**RESEARCH@TGH.ORG**](mailto:RESEARCH@TGH.ORG)

Thank you for your interest in performing/conducting your research project/study at Tampa General Hospital (TGH). In order for the Office of Clinical Research (OCR) to efficiently conduct our review, the following study documents are required to begin the process. Please select all documents that are included in your submission:

**For ALL studies the following documents must be submitted, as applicable:**

Research Study Proposal Form

Study protocol (Version date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

IRB Application **for Investigator Initiated studies (IIT)**. If there is no informed consent, the request for a waiver of Consent and Authorization must submitted with the application  **NA**

Data collection sheet (if applicable)  **NA**

Survey, questionnaires and scripts (if applicable)  **NA**

Current CV, signed and dated for the principal investigator

**For studies that involve TGH inpatient/outpatient units or require TGH bedside nursing support, the following documents must be submitted:**  **NA**

Unit Nursing Support and Awareness Worksheet – signed/dated

TGH Hospital Unit Support of Research Study letter – signed/dated by Janet Davis ([jdavis@tgh.org](mailto:jdavis@tgh.org) )

**For any nursing related research projects, notify the TGH Advanced Nurse Research Specialist in TGH Nursing Administration and submit:**   **NA**

TGH Nursing Administration Support of a Research Study letter – signed/dated by Mary Kutash

* + Instructions: If a study is a nursing study OR contains a survey or questionnaire that involves nursing staff, the PI/designee must submit the study documents to Nursing Administration, Mary Kutash ([mkutash@tgh.org](mailto:mkutash@tgh.org)), for review and approval. Documentation of nursing approval is required in order to proceed through the TGH review process.

**Informed Consent Form:**   **NA**

**If NA, documentation of/request for Waiver of Consent must be included.**

All Informed Consent/Assent Forms (Version date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

Documentation of/request for Waiver of Consent

HIPAA Authorization Forms (if separate document from Informed Consent Form) or request for / documentation of Waiver of Authorization (if applicable)  **NA**

**Business and Finance:**

Sponsor’s budget, funding memo/sheet, grant award, etc

(**Required for all funded studies)**  **NA**

CMS Approval Letter (device studies only)  **NA**

FDA Approval Letter for IND/IDE studies. Letters from sponsors are not acceptable.  **NA**

Clinical Trial Agreement/Work Order/Statement of Work, etc  **NA**

Purchase Agreement (if applicable)  **NA**

Coverage Analysis (if applicable)  **NA**

**Study Documents - Draft copies from sponsor are acceptable:**

Investigator Brochure (if applicable) – Drug Studies  **NA**

Instructions for Use (IFU) (if applicable) – Device Studies  **NA**

Imaging Manual (if applicable)  **NA**

Laboratory Manual (if applicable)  **NA**

EDC Manual (if applicable)  **NA**

Pharmacy Manual (if applicable)  **NA**

Other study related documents as available  **NA**

**For ALL drug and device/procedure studies, the following document must be completed and submitted:**

TGH Drug Research Information Sheet  **NA**

TGH Device/Procedure Research Information Sheet  **NA**

**The OCR will begin reviewing the research project/study once all required study documents are received by the OCR. If you need clarification on the required documents, please contact** [**research@tgh.org**](mailto:research@tgh.org)**.**

1. **General Information**

|  |  |
| --- | --- |
| Full Study Title: |  |
| Short Title: (descriptive title to be used for study ID in EPIC/EMR and CTMS |  |
| Study Protocol Number: |  |
| IRB #: | Pending available |
| NCT #: | NA  Pending available |
| Principal Investigator (PI) Name: |  |
| Study Phase | Pilot  Phase I  Phase II Phase III  Phase IV NA |

**Short Study Description:** (1-2 sentences summarizing the purpose of the study, 200 max character limit)

|  |  |
| --- | --- |
| What research activities will occur at TGH: (select ALL that apply) | Recruitment Enrollment (consent) Treatment  Labs  Diagnostics  Drug dispensing  Drug administration Follow-up Data collection  Surgery  Device Implant  Physical Exams  Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**PI Information**

|  |  |
| --- | --- |
| Affiliation and Department: |  |
| Mailing Address: |  |
| Telephone: |  |
| E-mail: |  |
| Pager/Cell Phone: |  |
| Credentialed at TGH? | Yes No Pending |
| Access to CTMS? | Yes No Pending |
| Access to VESTIGO? | Yes No Pending |

1. **Study Support Information**

|  |  |
| --- | --- |
| What TGH support will be needed? (select ALL that apply) | |
| Laboratory: NA | Sample Collection  Process Store  Ship Tumor specimen sample prep |
| Regulatory: NA | Regulatory Support  (Note: If services are requested, a fee schedule will be provided in the study acknowledgment e-mail, if applicable.) |
| Pharmacy:  NA | Storage Randomization Dispensing  (Note: If services are requested, a fee schedule will be provided in the study acknowledgment e-mail, if applicable.) |
| Study Coordinator: NA | I/E  ICF  IP admin  Questionnaires  Data entry  Other, specify: |
| IT: NA | Reports Data BPA Order Set  Other, specify: |
| Does the study involve software? | **Yes No**  **If yes, provide details:** |
| Other research support: NA | Specify: |

**List ALL services to be performed at TGH (complete the table below)**

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| --- | --- | --- | --- |
| Visit #/Name | Location where procedure, test, item, or service to be performed | Description of procedure, test, item or other service:  (ex. informed consent, EKG, imaging, specimen collection and/or processing. Include CPT/HCPCS code(s), if applicable) | Performed by TGH, TGH CORE Staff, or PI/External (non-TGH) Staff? |
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**Additional services can be listed on the last page of this application in section B.1.**

**\*\*FOR NON-TGH ENTITIES - PROFESSIONAL FEE INFORMATION:**

**If this study requires any of the services listed below (or other services/groups not listed that perform billing outside of TGH), non-TGH study sites must contact the following entities below for service related agreements.**

**Laboratory:** Please be advised that you may be charged laboratory reading fees by Ruffolo, Hooper and Associates. TGH has no control over the assessment of these fees. Please contact Ruffolo, Hooper and Associates at 813-890-0138 for service related agreement information.

**Radiology:** Please be advised that you may be charged radiology reading fees by Radiology Associates. TGH has no control over the assessment of these fees. Please contact Radiology Associates at 813-253-2721 for service related agreement information. **EKG:** Please be advised that you may be charged EKG reading fees by EKG Interpretation. TGH has no control over the assessment of these fees. Please contact 813-254-2441 for service related agreement information.

**Anesthesiology:** Please be advised that you may be charged anesthesiology professional fees by TeamHealth Anesthesiology. TGH has no control over the assessment of these fees. Please contact 813-258-3444, ext. 306, for service related agreement information. **If your study does not involve any additional professional services, then these fees are not applicable.**

1. **Study Details**

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| --- | --- | --- | --- |
| Number of Planned Subjects: |  | | |
| Study Type: (select ALL that apply) | Drug In Vitro Diagnostic (IVD)  Device Other, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Observational  Procedure/Surgery  Registry with blood draw  Registry  Quality Improvement (QI)  Biological Agent | | |
| Drugs/Devices/Agents/  Procedures Being Investigated (List by name): |  | | |
| Therapeutic Area of PI: | Allergy, Asthma and Immunology  Anesthesiology  Anthropology  Cardiology and  Cardiothoracic Surgery  College of Medicine  Critical Care and Trauma  Emergency Medicine  Engineering  Gastroenterology and  Digestive Diseases  Genetics and Metabolism  Hepatology  Infectious Disease  Internal Medicine | Infectious Disease  Internal Medicine  Laboratory  Mental Health  Molecular Medicine  Neonatology  Nephrology  Neurology and Neurosurgery  Nursing  OB/GYN  Oncology  Ophthalmology  Orthopaedics  Otolaryngology | Pastoral Care  Pathology  Pediatrics  Pharmacology  Pharmacy  Plastic Surgery  Poison Center  Public Health  Pulmonology  Radiology  Surgery  Transplant  Trauma Surgery  Urology  Other, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| IRB Name: | USF IRB  WIRB  Other, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Funding Source(s); (select ALL that apply) | Industry-Sponsored  Government Sponsored (e.g. NIH, DOD)  Investigator  Other funding, specify (e.g. industry funding; department funding; government or non-government grant support): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  N/A | | |
| Sponsor/Manufacturer: |  | | |
| Are the products FDA approved for use in the indication under study? | Yes No NA | | |
| IND/IDE/HDE Number: | OR NA | | |
| Who will purchase the investigational drug/device/agent? | Physician/Practice Group  Tampa General Hospital (advanced purchase)  Tampa General Hospital (consigned/leased from sponsor)  Sponsor will provide free of charge  Other, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  N/A | | |
| Where will the drug/device/agent be stored? | Physician/Practice Group  Tampa General Hospital Investigational Pharmacy  Sponsor will provide on a case-by-case basis  Other, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  N/A | | |

1. **Study Personnel**

**Sub-Investigators:**

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| Name: |  |
| Telephone: |  |
| E-mail: |  |
| Pager/Cell Phone: |  |

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| Telephone: |  |
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| Pager/Cell Phone: |  |

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| Name: |  |
| Telephone: |  |
| E-mail: |  |
| Pager/Cell Phone: |  |

**Additional Sub-Investigators should be listed in Section D.1.**

**Primary Study Coordinator (SC):**

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| --- | --- |
| Name: |  |
| Telephone: |  |
| E-mail: |  |
| Pager/Cell Phone: |  |
| Require access to TGH CTMS? | Yes No |
| Require access to USF CTMS? | Yes No |
| Require access to VESTIGO? | Yes No |
| Require access to ClinCard? | Yes No |

**Study Contact:**

|  |  |
| --- | --- |
| Name: |  |
| Telephone: |  |
| E-mail: |  |
| Pager/Cell Phone: |  |
| Require access to TGH CTMS? | Yes No |
| Require access to USF CTMS? | Yes No |
| Require access to VESTIGO? | Yes No |
| Require access to ClinCard? | Yes No |

**Any additional study personnel should be listed in Section D.2.**

**For sponsor studies:** **NA**

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| --- | --- |
| CRO Company Name: |  |
| CRO Primary Contact Name: |  |
| CRO Primary Contact Telephone: |  |
| CRO Primary Contact E-mail: |  |

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| Contract Contact Name: |  |
| Contract Contact Telephone: |  |
| Contract Contact E-mail: |  |

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| Budget Contact Name: |  |
| Budget Contact Telephone: |  |
| Budget Contact E-mail: |  |

1. **Education Plan**:

It is the responsibility of the study team and not TGH research staff to notify all affected TGH hospital units of the study. The unit manager and/or educator must approve of the study prior to release of the final TGH approval. This information should be captured in the **Unit Nursing Support and Awareness Worksheet. For any further questions, please contact** [**research@tgh.org**](mailto:research@tgh.org)**.**

Who will execute the education plan?

Sponsor  PI  Coordinator: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe your Education Plan for training or notifying all affected areas not captured in the Unit Nursing Support and Awareness Worksheet: (e.g. ECHO, Radiology, Lab, etc.)

:

1. **Research Activities at TGH:**

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| --- | --- | --- |
| Location(s) where research activities and education will occur: (select ALL that apply) | Specialty Surgery Unit  ACE Unit (Acute Care for the elderly)  Complex Medicine  Oncology Unit  Gynecology Unit  Trauma/Surgery  Primary Care  Neurosciences  Psychiatric  Burn Center  Orthopaedics  Joint Center  Short Stay Center  GE Center  Main OR  Cardiac OR  Cardiac Cath Lab  Angio/Interventional  Suites:  Outpatient Surgery  Pre-op/Surgical Prep Unit  PACU  Bariatric Center  Outpatient Diagnostics  Outpatient Laboratory  Pediatric Day Hospital  Services:  Pathology  Infusion/Cancer Center  ER  ICU—Trauma/Surgical  ICU—Neurosciences | ICU—Medical  ICU - Vascular  CTICU  CCU  Cardiac Transition  Cardiac/Vascular/Telemetry  3K/CV Center  Adult Step-Down  Cardiac Care  Transplant  Pediatric Medical/Surgical  PICU  NICU  Labor & Delivery  Antepartum/Postpartum  Pediatric Dialysis  Rehabilitation  Adult Dialysis  Other, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Clinics:  30th Street—Pediatrics  30th Street—Genesis  Kennedy—Family Practice  Outpatient Rehabilitation  Harbourside Medical Tower (HMT)  409 Bayshore Transplant Clinic – 4th floor  CORE: 5th floor 409 Bayshore  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Financial Disclosure**

Does PI or any investigator receive any financial compensation from the study sponsor?

YES  NO

**Submitter Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INTERNAL USE ONLY:**

Office of Clinical Research Acknowledgement of Receipt

Received by:

Date Complete Submission Received:

OCR Review Start Date:

Upon review completion, signature and date of reviewer:

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| B.1. Additional services | | | |
| Visit #/Name | Location where procedure, test, item, or service to be performed | Description of procedure, test, item or other service:  (ex. informed consent, EKG, imaging, specimen collection and/or processing) | Performed by TGH, TGH CORE Staff, or PI/External (non-TGH) Staff? |
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**Section D.1. Complete the below information for any additional Sub-Investigators:**

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| Section D.2. Complete the below information for any additional study personnel | |
| Name: |  |
| E-mail: |  |
| Role: |  |
| Require access to TGH CTMS? | Yes No |
| Require access to USF CTMS? | Yes No |
| Require access to VESTIGO? | Yes No |
| Require access to ClinCard | Yes No |

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| --- | --- |
| Name: |  |
| E-mail: |  |
| Role: |  |
| Require access to TGH CTMS? | Yes No |
| Require access to USF CTMS? | Yes No |
| Require access to VESTIGO? | Yes No |
| Require access to ClinCard | Yes No |

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| --- | --- |
| Name: |  |
| E-mail: |  |
| Role: |  |
| Require access to TGH CTMS? | Yes No |
| Require access to USF CTMS? | Yes No |
| Require access to VESTIGO? | Yes No |
| Require access to ClinCard | Yes No |

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| --- | --- |
| Name: |  |
| E-mail: |  |
| Role: |  |
| Require access to TGH CTMS? | Yes No |
| Require access to USF CTMS? | Yes No |
| Require access to VESTIGO? | Yes No |
| Require access to ClinCard | Yes No |

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| --- | --- |
| Name: |  |
| E-mail: |  |
| Role: |  |
| Require access to TGH CTMS? | Yes No |
| Require access to USF CTMS? | Yes No |
| Require access to VESTIGO? | Yes No |
| Require access to ClinCard | Yes No |