San Francisco General Hospital
PROTOCOL APPLICATION

Protocol Title: _____

_____

Grant Title (if different) _____

_____

Grant No. if available _____ **Beg. Date of Grant** _____ **End Date of Grant** _____

Prin. Investigator _____ **Additional Contact** _____

Phone _____ Phone _____

Mailing Address _____ Mailing Address _____

IRB STATUS

□ Approved CHR No._____ Exp. Date_____

SUBJECT CATEGORY Please circle appropriate classification

1 Subjects seen for research purposes only
Source of funding (e.g., NIH, industry, other)_____

2 Subjects seen for research and for established medical care
Source of funding (e.g., NIH, industry, other)_____

BRIEF DESCRIPTION OF PROTOCOL Please provide a brief description of the nature and goals of the study

_____

_____

_____

UTILIZATION

Indicate number of subjects per year Year 1 _____ 2_____ 3_____ 4_____ 5_____

□ Total number of outpatient visits per subject _____

□ Total number of inpatient visits per subject _____

CHART REVIEW/PATIENT DATA (MUST BE SIGNED IF YOU ARE USING ANY SFGH/DPH PATIENT DATA)

Use of SFGH/DPH patient information is approved: Yes □ NA □#

_____
Signature/Date: Director, Medical Records
Or attach email approval from Director, Medical Records

Per HIPAA regulations, all patient health information (PHI) will be encrypted/password protected if stored on computers and/or portable electronic devices. PI please initial/date here _____

****If this is a chart review only, STOP here.****

Send signed and completed SFGH Research Protocol Applications to the SFGH Vice Dean's office, Box 0809 or fax to 285-2037.
For questions regarding the application please call 415-206-8509

Will this study be conducted entirely in the SFGH Clinical Translational Science Institute (CTSI) Clinical Research Center (CRC)? Yes □ No □#

If "Yes", proceed to "Pharmacy Utilization" section and contact SFGH GCRC 206-8239 for required forms.

If "No", please complete all of the following. Note any SFGH equipment, services, or personnel needed, and department(s) involved. Sign all sections where you indicate "NA".

HUMAN RESOURCE / SPACE UTILIZATION (approval from the Unit where research will occur)

Where will this study be conducted? Building _____ Room _____

Please describe any and all tasks which SFGH staff may be asked to perform which they would not perform but for this protocol: _____

_____

I have approved the above: Yes □ No □#

#

#

_____

Signature/Date: Unit Head Nurse / Manager

Or attach email approval from Unit Head Nurse / Manager

CLINICAL LABORATORY UTILIZATION (206-8588)

A SFGH Special Research Account has been established? Yes □ NA □#

#

_____

Signature/Date: SFGH Clinical Lab Administration

Or attach email approval from SFGH Clinical Lab Admin.

If applicable, refer to Procedure for Establishing and Using a Research and Special Study Account.

RADIOLOGY UTILIZATION (206-5196 or 206-6130)

A SFGH Special Research Account has been established? Yes □ NA □#

#

_____

Signature/Date: SFGH Radiology Administration

Or attach email approval from SFGH Radiology Admin.

If applicable, refer to Procedure for Establishing and Using a Research and Special Study Account.

PHARMACY UTILIZATION (206-8460) (MUST BE SIGNED IF YOU ARE ADMINISTERING ANY MEDICATION)

Does this study involve the administration of **any** medications? Yes □ No □

A SFGH Pharmacy Investigational Drug Service (IDS) form has been completed? Yes □# NA □#

#

_____

Signature/Date: SFGH Pharmacy Administration

Or attach email approval from SFGH Pharmacy Admin.

ADMINISTRATIVE APPROVAL

_____ _____

A. Sue Carlisle, Ph.D., M.D. (Date) Susan A. Currin (Date)
Vice Dean, SFGH Executive Administrator

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