



APeX New Clinical Trial Study Request Form

Study Type

Study Name, beginning with ZZxxxx, Study

Maximum length is 25 characters

Study Description

Full Study Title

CHR # / CAR # (Study Code)

Chart of Accounts (COA)

*Dept ID (6-digits) - Fund (4-digits) -
Function (2-digits) - Project (7-digits) -
Activity Period (2-digits)*

Please make sure you follow the above format for your COA.

Consult with your Financial Manager for this info

If the study has a Chart of Account (COA) Change, please provide a new Effective Date.

National Clinical Trial # (NCT)

You must include this if your study qualifies for an NCT#

If an NCT# is not applicable, please mark NA.

You can visit www.clinicaltrials.gov to see if you qualify

Funding Source

This will be completed by the OCR Intake Team

Department

This should be the home department of the Principal Investigator

Anesthesia and Pain Management
Dermatology
Medicine excluding Hematology/Oncology
Medicine Hematology/Oncology
Neurologic Surgery
Neurology
Obstetrics and Gynecology
Ophthalmology
Orthopedic Surgery
Osher Center for Integrative Medicine
Otolaryngology
Pediatrics
Radiology
Radiation Oncology
Surgery
Urology
Proctor Foundation
Other

Key Contact Name

This is the person who will receive your MONTHLY Research Statements

Key Contact Address

Address, City, State, Zip

Key Contact Phone #**Key Contact Fax #****Principal Investigator Name and ID**

(e.g. Gregory House, MD 61175)

Primary CRC Name and ID

This should be the main contact for the study and/or the CRC responsible for billing review.

Other CRCs Name(s) and ID(s)

Please list any other CRCs related to this study.

Nurse(s) and ID(s)

Co-investigator(s) and ID(s)

Clinical Trial?

Yes

No

Device Trial?

Yes

No