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

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