

 <b>WOMEN'S COLLEGE HOSPITAL</b> Health care for women   REVOLUTIONIZED	FOR INTERNAL USE ONLY	DATE RECEIVED:
<b>WCRI SUBMISSION FORM FOR RESEARCH ACTIVITIES (MUST ACCOMPANY ALL GRANT SUBMISSIONS)</b>		

**1. PRIMARY WCH INVESTIGATOR:**

Full Name (Last, First)	Phone:	E-mail:
Department	Clinical Department Chief	
Is the applicant's primary research appointment at WCH? Yes <input type="checkbox"/> No <input type="checkbox"/>		
I assume full responsibility for the scientific and ethical conduct of the project. I agree to conduct this study in compliance with the applicable WCH policies and will disclose any conflicts of interest or potential conflicts.		
Primary WCH Investigator (Print Name )	Date:	Signature

**2. CO-INVESTIGATORS (NAME, INSTITUTION):**

CO-INVESTIGATORS NAME	INSTITUTION	READ AND APPROVED FULL DRAFT OF GRANT
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

**3. PROJECT INFORMATION:**

Project <input type="checkbox"/> New <input type="checkbox"/> Renewal <input type="checkbox"/> Re-submission	Grant <input type="checkbox"/>	Award <input type="checkbox"/>	Fellowship <input type="checkbox"/>
<b>Sponsor:</b>	<b>Competition Deadline Date</b>		Electronic Submission? Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>Title:</b>			
<b>Total Budget \$</b>	<input type="checkbox"/> This project has potential commercial application		
If successful, will funds be held at WCH? Yes <input type="checkbox"/> No <input type="checkbox"/>	Hiring Grad Students? Yes <input type="checkbox"/> No <input type="checkbox"/>		

**4. INVOLVEMENT OF OTHER INSTITUTIONS:**

Yes*	No	*inter-institutional agreement may be required
<input type="checkbox"/>	<input type="checkbox"/>	Will funds from the proposed activity be sent to any other institution/org? contact info: amount:\$

**5. STUDY IMPACT ON HOSPITAL DEPARTMENTS OR SERVICES:**

Does the study impact on other hospital departments or services? Yes  No

If yes, provide signature(s) to indicate that the protocol has been submitted to the appropriate department.

**NB:** The Principal Investigator is responsible for all successful negotiations with departments.

Department	Impact	Departmental/Divisional Signature
Anesthesia	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Medicine	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Medical Imaging	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Nursing	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Pharmacy	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Surgery	Yes <input type="checkbox"/> No <input type="checkbox"/>	
	Yes <input type="checkbox"/> No <input type="checkbox"/>	

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**6. STUDY TYPE**

Indicate the level of risk associated with this study by marking **ONE** of the boxes in the matrix below with an x.

RESEARCH CATEGORY	Please check one:
A. Observational Studies involving <b>deidentified</b> information <b>No Direct Participant Contact</b>	<input type="checkbox"/>
B. Observational Studies involving personal health/identifying information <b>No Direct Participant Contact</b>	<input type="checkbox"/>
C. Observational Studies involving participant contact but <b>no physical exams</b>	<input type="checkbox"/>
D. Observational Studies involving participant contact with physical exams/ physiological assessments but <b>without biological specimens</b>	<input type="checkbox"/>
E. Observational Studies involving participant contact with physical exams/ physiological assessments and <b>biological specimens</b> (blood, urine, tissue)	<input type="checkbox"/>
F. Clinical Trial	<input type="checkbox"/>

Does this study involve WCH patients? Yes  No

**7. PEER REVIEW (PRE-SUBMISSION)**

Did this submission receive peer review? Yes  No

Please provide details on the peer reviewers:

NAME	INSTITUTION	EXPERTISE RELATED TO GRANT
1.		
2.		
3.		

Have all sections of the grant been peer-reviewed? Yes  No

If this is a re-submission, did the original submission receive peer review? Yes  No  N/A

**If yes**, were the same reviewers used for this submission? Yes  No

**8. KEY FOCUS (CHECK ALL THAT APPLY):**

- Women's health
- Chronic disease
- Ambulatory care
- Sex and/Gender differences
- Other:

**PARTNERSHIPS (CHECK ALL THAT APPLY):**

- Community specify:
- Vulnerable population(s): specify:
- International specify:
- Other: