  

# TRI-HOSPITAL RESEARCH ETHICS BOARD (THREB)

### ADMINISTRATIVE/INSTITUTIONAL APPROVAL OF RESEARCH PROJECT

## Part 3

It is the responsibility of the research to contact each hospital to discuss the requirements for Administrative Approval prior to submission of Application Documents (Parts 1-3) to THREB

 **Project #** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (will be assigned by THREB)

**1. Local Responsible Investigator:** Click here to enter text.

**2. Principal Investigator** (if different from local): Click here to enter text.

**3. Project title** (max 400 characters)**:**

|  |
| --- |
| Click here to enter text. |

**4. Executive Summary**

 a. Research Question (max 350 characters):

|  |
| --- |
| Click here to enter text. |

 b. Setting (Where will the study take place?):

[ ] Cambridge Memorial Hospital [ ] Grand River Hospital

 [ ] St. Mary’s General Hospital [ ] Grand River Regional Cancer Centre

 [ ] Community – specify: Click here to enter text.

 [ ] Other – specify: Click here to enter text.

c. Identify any staff involvement (max 250 characters):

|  |
| --- |
| Click here to enter text. |

 d. Interventions involved including diagnostic and labwork:

 Are any interventions non-standard? [ ] Yes [ ] No If “yes” which (max 250 characters) ?

|  |
| --- |
| Click here to enter text. |

e. Expected number of participants: Click here to enter text.

f. Will access to personal health information (e.g. charts) be required? [ ] Yes [ ] No

g. Resource Utilization Form (attached) is submitted: [ ] Yes [ ] No

**5. Contract**

 Is there a contract involved? [ ] Yes [ ] No

 If “yes” is the institution named in the contract [ ] Yes [ ] No

If “yes,” has the contract been submitted to the institution? [ ] Yes [ ]  No

**NOTE**: If there is a contract, authorization to begin a study will require a completed contract approved by the institution.

**6. ADMINISTRATIVE APPROVAL**

I have reviewed the attached protocol and confirm that resource and contract issues at this institution have been or are being satisfactorily addressed and I give administrative approval for the THREB review of this project.

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Signature)

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

 (Print name) (Date)

 Institution\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# CMH_K_3

For CMH: Stephanie Pearsall 519-621-2333 x2416

For GRH: Carla Girolametto 519-749-4300 x2307

For SMGH: Sherri Ferguson 519-749-6403

**RESOURCES UTILIZATION TEMPLATE PAGE FOR**

### THREB Associated Hospitals

**NOTE: This Resource Utilization Template is only a reference model and will be adapted in different ways by each of the three hospitals. Contact the person responsible for administrative approval to clarify the approval process in a particular hospital.**

**THREB itself requires only the signed Administrative Approval page and the budget.**

**Requirements:**

* It is the responsibility of the applicant to ensure that all areas from which resources will be required have been consulted and have indicated agreement by signing this form.
* Approval of the project is conditional upon satisfactory completion of this section.
* A separate resources form must be filled in for each institution in which the research will be conducted.
* If a required area has not been consulted and approval received, the application may be returned for completion.

**Institutional Services, Staff or Equipment:**

* If your participant will be admitted to hospital and/or will require any hospital services, as a requirement of this study, which are over and above standard treatment, you **must** obtain appropriate signatures.
* If the study involves more than one unit or service in the hospital, signatures **must** be obtained from all areas involved.
* In all cases, budgets should cover institutional costs and overhead if required, unless otherwise agreed upon by the appropriate Administrator.

**Health Records/Health Information/Decision Support Services:**

1. Will you require **Health Records/Information** to pull charts for you? [ ] YES [ ] NO

2. Will you require **Decision Support** Services to identify your research population? [ ] YES [ ] NO

3. Do you require patient specific data from **Decision Support** to support your project? [ ] YES [ ] NO

4. Do you require summary cost data to support your project? [ ] YES [ ] NO

5. If **YES** to any of 1 to 4 above, have you allowed for these services in the budget? [ ] YES [ ] NO

**CHECK AREAS BELOW WHERE RESOURCES ARE REQUIRED (✓)**

|  |  |  |
| --- | --- | --- |
| **Area** | **Authorized Official** | **Signature** |
| [ ] **Health Information/Records**  | Click here to enter text. |  |
| [ ] **Decision Support** | Click here to enter text. |  |
| [ ] **Laboratory Services** | Click here to enter text. |  |
| [ ] **Medication/Drugs**(*Pharmacy)* | Click here to enter text. |  |
| [ ] **Radiology/Diagnostic/Medical Imaging Resources** | Click here to enter text. |  |
| [ ] **Nuclear Medicine** | Click here to enter text. |  |
| [ ] **Radiation Safety** | Click here to enter text. |  |
| [ ] **Other** (*please specify)*Click here to enter text. | Click here to enter text. |  |

**Approvals are required from individuals responsible for nursing and clinical care of each patient area to be utilized**

|  |  |  |
| --- | --- | --- |
| **Hospital Area** **(E.g. Inpatient/Outpatient Location)** | **Authorized Official****(Manager/Director)** | **Signature** |
| Click here to enter text. | Click here to enter text. |  |
| Click here to enter text. | Click here to enter text. |  |
| Click here to enter text. | Click here to enter text. |  |
| Click here to enter text. | Click here to enter text. |  |
| Click here to enter text. | Click here to enter text. |  |
| Click here to enter text. | Click here to enter text. |  |

|  |  |
| --- | --- |
|  | Click here to enter a date. |
| Signature of Local Responsible Investigator | Date |
|  |  |

**RESEARCH ETHICS BOARD**

**BUDGET TEMPLATE**

**Study title:** Click here to enter text.

**Local Investigator:** Click here to enter text.

**Estimated Itemized Cost Per Participant**

 # Visits x Cost = Total

**History & Physical** (or other       =

 remuneration to investigators)

**Imaging:** X-rays       x       =

 Ultrasound       x       =

 Bone Scans       x       =

 CT Scans       x       =

 MRI       x       =

 Other (specify)       x       =

**Lab Work:**

 Haematology       x       =

 Chemistry       x       =

 Urinalysis       x       =

 Pathology       x       =

Other (specify)       x       =

**ECG**       x       =

**Pharmacy**       x       =

**Reimbursements and**

**other payments to Participants**       x       =

 **Total Cost Per Participant** =       (a)

 **Total Participant Costs:**       **Participants x** (a) =       (b)

**Personnel Costs**

1. Nurse/Coordinator @ $/hr x hrs/pt x n pts =

2. Nurse/Coordinator @ $/hr x hrs/pt x n pts =

3. Nurse/Coordinator @ $/hr x hrs/pt x n pts =

 **Total Personnel:** =       (c)

**Equipment Costs**

Specify equipment =

 **Total Equipment:** =       (d)

**Administrative Costs**

Administrative (Meetings, telephone, stationery, etc.) =

 **Total Administrative Costs:** =       (e)

**Industry-Sponsored Studies**

**Hospital Overhead** for Industry-Sponsored Studies =

**REB Admin Fee** for Industry-Sponsored Studies ($3000) =

 Total Indirect Costs: =       (f)

 Total Cost for Complete Study: =       (b+c+d+e+f)

*N.B. If your budget is reported as cost/patient enrolled, be sure to provide a detailed justification of what is included in the cost/patient (i.e. how many hours of nursing time, etc.).*