REQUEST FOR ASSISTANCE

PI Name:
Dept #:
CB#
Phone: Fax: E-mail:

Department Billing Contact:
Phone: Fax: E-mail:

CRC Name:
Phone: Fax: E-mail:

Protocol Title & IRB Number
______________________________________________
________________________________________________________________________

Anticipated Number of Patients:_______ Anticipated Visits/Patient ______

Sponsor/CRO: ___________________ Contact: ___________________
E-mail:_____________ Telephone:_____________ Fax: __________

Submitted the CTRC Addendum YES NO (circle one)

PI Signature______________________________ Date __________________

WE NEED (check all that apply):

_____ The REGULATORY PAPERWORK done by the CTRC (sponsor’s documents, IRB paperwork, IDS and contracting requests, etc.) for the above study (Payment for this service is the start up fee negotiated in the sponsor’s budget)

_____ To use the CTRC CLINICAL RESEARCH COORDINATOR to be the Study Coordinator in place of our department/division coordinator for the above study

PLEASE FAX This request form to: 966-1576