

RESEARCH APPLICATION COVER PAGE

^A <i>Principal Investigator:</i>	^{A1} <i>Phone:</i>	^{A2} <i>E-Mail:</i>
^B <i>Sub-Investigator(s):</i>	^{B1} <i>Phone:</i>	^{B2} <i>E-Mail:</i>
^C <i>Study Coordinator(s):</i>	^{C1} <i>Phone:</i>	^{C2} <i>E-Mail:</i>
^D <i>Key Research Personnel:</i>	^{D1} <i>Phone:</i>	^{D2} <i>E-Mail:</i>
^E <i>Title of Study:</i>		
^F <i>Sponsor or Funding Source (Manufacturer/Company or NIH; FDA; CDC, etc.):</i>		^G <i>Protocol Number, Version and Date:</i>

1. This application is for a: *(please select all that apply)*

- New Study
- Continuing Review:
 - renewed without change – upcoming expiration date: _____
 - renewed with amendments – upcoming expiration date: _____
- Revision/Amendment – amendment number, new protocol version and date: _____
- Non-protocol related changes or corrections (changing of research team member, etc.): _____
- Reopening of expired study - expiration date: _____
- Study Closure

2. The primary purpose of this protocol involves:

- An investigational new drug or device:
 - an investigational drug (IND# _____)
 - an investigational device - as determined by the sponsor, the device is:
 - non-significant risk significant risk (IDE# _____)
- A radioisotope
- Human tissues/specimens for analysis
- Human tissues/specimens collected for future research use
- Record review/Survey/Post market approval study
- Other _____

3. The population studied includes: *(check all that apply)*

- Adults
- Children/Fetuses
- Homeless individuals
- Substance users

Please note: SBCH IRB cannot review research in which prisoners are the intended research population.

4. Are the subjects/LARs aware of their participation in the research?

Yes No

Are you requesting a waiver of either of the following (if so, you must complete the Waiver of Authorization Request):

Waiver of Consent

Consent Waiver granted previously

Waiver of HIPAA Authorization

HIPAA Authorization Waiver granted previously

5. Will any portion of this study be conducted at a Cottage Health Facility?

Yes No

If YES, please check which facility: (*check all that apply*)

Santa Barbara Cottage Hospital (Eye Center OPS Cottage Structural Heart Clinic Other)

Cottage Rehabilitation Hospital

Goleta Valley Cottage Hospital

Santa Ynez Valley Cottage Hospital

Pacific Diagnostics Laboratory

6. Other sites where the study will be conducted:

Sutter Health (*specify locations(s)*): _____

Other location(s): _____

My signature below attests that the information given in this application is correct to the best of my knowledge and that I will fulfill my obligations as an investigator, as required by federal regulations.

Principal Investigator Signature: _____ Date: _____