Providence Health Care
How you want to be treated.

Providence Research
We're all in.

PHC Program Utilization Form

For programs that do not provide their own utilization form, please complete the below.

Once signatures have been applied, please send a copy to paula.piper@phc.ca

Principal Investigator: _____

REB #: _____

Name of Sponsor: _____

Study Start/End Date: _____

Project Title: _____

Primary Contact: _____

Email: _____

1. Indicate the PHC Program(s) in which the study will be carried out:

_____

2. Hospital Venue: ☐ Clinic ☐ Unit/ Ward ☐ Department

3. How many subjects will be participating at the PHC site? _____

4. How many controls will be participating at the PHC site? _____

5. List tasks required of **Hospital Employees** in this Program for this study, by Hospital area:

_____

6. List study activities conducted in the Program by non-Program Staff (e.g., Research/ Lab personnel):

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7. List any PHC medical records that you will need access to: (PLEXIA, Sunrise Clinical Master, Cerner/ CST etc.) ** Note CareConnect is not approved for research purposes.

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8. It is the investigator's responsibility to orient staff that will be involved in this study. If applicable, describe how Hospital employees in this Program will be oriented to this study.

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* It is the responsibility of the Programs to determine if these services will have sufficient impact as to require recovery from the research study budget to offset hospital operating costs. It is the responsibility of the Programs to provide investigators with the cost of those services.

NOTE: The below should be signed by the patient care manager or leader of the department/ clinic, it should **NOT** be signed by the PI or anyone listed on your application.

SIGNATURE:

PRINT NAME:

DATE:

DEPARTMENT/ POSITION:

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*For a list of Program/Resource Signing Authorities & other forms, please visit the PHC REB website: https://www.providenceresearch.ca/en/institutional-approvals#hospital-approval-forms--12681