



**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 [ppiper@providencehealth.bc.ca](mailto:ppiper@providencehealth.bc.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 (eg. Research/ Lab personnel):

\_\_\_\_\_

7. 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.

\_\_\_\_\_

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.



How you want to be treated.



PROVIDENCE HEALTH CARE  
Research Institute

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**SIGNATURE:** \_\_\_\_\_

**PRINT NAME:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

**DEPARTMENT/ POSITION:** \_\_\_\_\_

\*For a list of Program/Resource Signing Authorities please visit the PHC REB website:

[https://www.providenceresearch.ca/sites/default/files/PHC%20Hospital%20Approval%20Contact%20-%20Feb%202021\\_0.pdf](https://www.providenceresearch.ca/sites/default/files/PHC%20Hospital%20Approval%20Contact%20-%20Feb%202021_0.pdf)