Providence HEALTH CARE
How you want to be treated.

Providence Research
We're all in.

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

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.

Providence HEALTH CARE
How you want to be treated.

Providence Research
We're all in.

PROGRAM UTILIZATION FORM

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