

USF/TGH Office of Clinical Research
Medical Writing Services
Service Request Form

Principal Investigator:

(Address/ phone/ fax/ pager/ e-mail)

Co- Investigators:

(Address/ phone/ fax/ pager/ e-mail)

Study Coordinators:

(Address/ phone/ fax/ pager/ e-mail)

Are you affiliated with USF? Yes / No

If Yes, please circle one of the following designations: Faculty Staff Student/Resident

College/Department: _____

If No, please enter your affiliation:

Protocol Title:

(The full title used in the IRB protocol submission and the consent form must exactly match the protocol title submitted here)

Study Category:

- Investigator Initiated
- Industry Initiated
- Other

Current Grant or Project Support:

Federal: _____ Grant title: _____

Investigator Sponsored: _____

Department Sponsored: _____

Industry Sponsored: _____

Other: _____

IRB Status:

Approved Review pending Not yet submitted Contingent approval

USF IRB No: _____

WIRB IRB No: _____

Type of Assistance Requested (Please Check All that Apply):

New Study		Existing Study		Other Services	
Protocol development	<input type="checkbox"/>	Protocol review	<input type="checkbox"/>	Abstract review	<input type="checkbox"/>
Consent form development	<input type="checkbox"/>	Consent form review	<input type="checkbox"/>	Manuscript review	<input type="checkbox"/>
IRB application assistance	<input type="checkbox"/>	IRB consultation	<input type="checkbox"/>	Grant review	<input type="checkbox"/>
TGH / OCR application assistance	<input type="checkbox"/>	IRB review	<input type="checkbox"/>	Other	<input type="checkbox"/>

Please Provide a Brief Summary of Your Project:

Study summary should include the following:

Hypothesis: _____

Background/significance: _____

Study phase: _____

Duration of the study: _____

Methodology: _____

Research question: _____

Study Site: _____

Number of subjects: _____

Main inclusion/exclusion criteria: _____

Statistical plan: _____

Study product, route of administration and regimen to be followed:

Any protocol amendments should also be mentioned with the amendment number and date:

Date Submitted: _____

Date Desired: _____

Please return your completed form to

Sadaf Aslam, MD

Medical Writing Services

Office of Clinical Research

Fax: 813-844-8121

E-mail: saslam@health.usf.edu

Or

Send it to research@tgh.org or faxed to 813-844-1165

For Office of Clinical Research staff only

Date Received: _____ Received By: _____

Referred To: _____ Date Referred: _____