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**Clinical Research Hospital Impact Checksheet**

Please complete this form if your proposed clinical research project will use CVM hospital facilities or services. PIs are asked to discuss the impact of their proposal with relevant services to ensure that appropriate staffing and resources can be allocated. Please submit the completed form by emailing this form along with your client consent form and project proposal description to mindyq@vt.edu.

PI Name: Click here to enter text.

Project Name:Click here to enter text.

Funding Source and Amount:Click here to enter text.

Estimated Project Start and End Dates: Click here to enter text.

IACUC Approval Number (if applicable): Click here to enter text.

**Required Attachments**

Project proposal/description as submitted to funding agency, or 1-page project summary.

Has your project undergone a scientific peer review?  **Yes**  **No**

*If your project has not undergone a scientific peer review (i.e. start-up funding or direct private funding), the project must undergo a further review by an ad-hoc committee consisting of members of the college’s standing research committee. We will coordinate that review on your behalf. Please contact Mindy Quigley with questions.*

Client Consent Form (sample forms can be downloaded from the VCRO Investigator Support website: <http://www.vetmed.vt.edu/clinical-trials/investigator-support.asp>)

*The investigator is responsible for following hospital financial management procedures.*

*For VTH projects, please contact Stacy Ferrell (*[*ferrells@vt.edu*](mailto:ferrells@vt.edu)*, VTH Business Office Supervisor*

*For ACCRC projects, please contact Deb Akers, (*[*dsakers@vt.edu*](mailto:dsakers@vt.edu)*), ACCRC Practice Manager*

*For EMC projects, please contact Patrick Wolak (*[*pwolak@vt.edu*](mailto:pwolak@vt.edu)*), Manager of Operations and Hospital Support Services*

Location where this project will take place:

Please check all that apply, and provide details in the table below.

ACCRC  EMC  VTH  Other: Click here to enter text.

|  |  |
| --- | --- |
| Item | Description of Need (Only for resources beyond what would be required as part of a normal individual patient visit or an indication of need per unit if samples or data will be obtained in batches.) |
| Exam rooms | Click here to enter text. |
| Overnight housing | Click here to enter text. |
| Diagnostic equipment (please specify) | Click here to enter text. |
| Hospital supplies | Click here to enter text. |
| Personnel other than investigators | Click here to enter text. |
| Radiology | Click here to enter text. |
| Linear Accelerator | Click here to enter text. |
| Anesthesiology | Click here to enter text. |
| Clinical Pathology | Click here to enter text. |
| Histopathology | Click here to enter text. |
| Sample handling support (receiving or mailing) | Click here to enter text. |
| Medical Records | Click here to enter text. |
| Necropsy | Click here to enter text. |
| IT Resources | Click here to enter text. |
| Pharmacy | Click here to enter text. |
| Other | Click here to enter text. |