

**MedStar Research Institute-Georgetown University
Oncology Institutional Review Board**

Request for Network Participation in Study by New Site

Initial Site Information

Initial MRI-GU Principal Investigator:	
Initial Site	
MRI-GU IRB Number:	
Title:	
# Subjects at Initial Site:	
Initial Site Coordinator Name:	
Initial Site Coordinator Phone:	
Initial Site Coordinator E-mail:	

New Site Information

New Site Name:	
New Site Principal Investigator:	
New Investigator Phone:	
24-Hour Phone Number:	
# Subjects at New Site:	
New Site Coordinator Name:	
New Site Coordinator Phone:	
New Site Coordinator E-mail:	

Co-investigators, if any for New Site	Title	E-mail Address	Phone Number

Signatures

- I agree to take responsibility for the conduct of this research at my facility and to promptly report any serious adverse events or protocol deviations to the primary site for submission to the IRB.
- I certify that the information furnished concerning the procedures to be taken for the protection of human subjects is correct. I will seek and obtain prior approval for any modification in the protocol or informed consent document and will report promptly any unexpected or otherwise significant adverse effects encountered in the course of this study.
- I certify that all individuals named as consultants or co-investigators have agreed to participate in this study.
- I assure that the protected health information identified on the “Medical Records Release and General Authorization to Use and Disclose Health Information for Research” and the persons and entities that may use, give and receive protected health information is accurate and reflective of the known use and disclosure for this human clinical study.

_____ Printed/Typed Name of New Site Principal Investigator	_____ Telephone number
_____ Signature of New Site Principal Investigator	_____ Date
_____ Printed/Typed Name of Department Chair	Department Chair: <input type="checkbox"/> Approved <input type="checkbox"/> Disapproved
_____ Signature of Department Chair New Site	_____ Telephone Number _____ Date
If this protocol is a local investigator initiated study, please have the initiating site Principal Investigator complete the following information:	
_____ Printed/Typed Name of Initiating Site Principal Investigator	_____ Telephone number
_____ Signature of Initiating Site Principal Investigator	_____ Date

Please attach one Copy of the following forms for Site Lead Investigator and **ALL** Site Co-Investigators

- Certificate of Completion for HIPAA training and HIPAA forms
- Certificate of Completion of Education in the Protection of Human Research Subjects
- Investigator’s qualifications (CV, biosketch, or Form 1572, if available)
- Conflict of Interest or Financial Disclosure (Form 3455 is sufficient)
- If this project involves an FDA regulated drug or device, FDA form 3455 and 1572